MEDICARE HOME HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON COMMERCE HOUSE OF REPRESENTATIVES

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MEDICARE HOME HEALTH CARE

WEDNESDAY, MARCH 5, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Klug, Deal, Burr, Bilbray, Whitfield, Ganske, Norwood, Coburn, Brown, Green, DeGette, and Eshoo.

Staff present: Howard Cohen, majority counsel, and Bridgett Taylor, minority counsel.

Mr. BILIRAKIS. Good morning. The hearing will come to order.

Today we convene this hearing of the Health and Environment Subcommittee to discuss home health services as provided as part of the Medicare program. It's fitting that we discuss this important issue for a number of reasons.

First, our hearing today comes at a time when the costs of Medicare home health continue to experience extraordinary explosive growth. Home health, as we know, is one of the fastest-growing components of Medicare, and home health spending has grown from $2 billion in 1987 to $20 billion this year, and that's an average growth rate of more than 25 percent per year. Today nearly 10 percent of Medicare beneficiaries use some form of home health services.

Another reason to discuss home health is the President's 1998 budget which has proposed moving home health from Medicare Part A to Part B. If shifted into Part B, as proposed by the President, home health services would be fully financed by general revenues and would not be subject to the conditions of other Part B services.

We will hear from three panels of witnesses today. Our first panel is Mr. Bruce Vladeck, the Administrator of the Health Care Financing Administration, and we thank Mr. Vladeck for appearing. We're spending a lot of time together these days. We look forward to his testimony.

The second panel will consist of witnesses from the Health and Human Services Office of Inspector General, the General Accounting Office, and the Prospective Payment Assessment Commission. They will provide us with some insight into the operations of home health.

And, finally, the third panel will consist of industry representatives who will give us their perspective on home health benefits.

One of key issues today will be the implementation of a prospective payment system for Medicare home health. There's a general consensus, I think, that a new payment system is necessary to control the cost of home health. The last Congress included in its Balanced Budget Act a prospective payment system for home health. Even though the President chose to veto that act, his recent budget proposal includes the new payment system for home health, and we look forward to learning more about the administrations' proposals.

Another issue of importance is the problem of fraud in home health services. The GAO has reported that—and I quote them—"Few home health claims are subject to medical review and most claims are paid without question." Because of this, the home health sector has often been abused by less scrupulous providers, and we look forward to finding ways to combat this fraud, so that the American people get the best value for their dollar.

I'd like to thank our witnesses in advance for joining us today, and I look forward to their testimony.

I want to really speed up these opening statements. Five minutes for Mr. Brown, a maximum of 3 minutes, hopefully less, for the other members who are here, and I do thank them in advance for preparing for this hearing.

Mr. BROWN. Mr. Chairman, my opening statement will be less than 5 minutes. Thank you, Mr. Chairman.

Home health services under Medicare, as we all know, have grown at a phenomenal rate. Overall, total home health expenditures under Medicare have grown from under $2 billion in fiscal year 1987 to $16-plus billion in fiscal year 1995. There are a number of reasons for this trend, some obvious, some not so obvious. More seniors are using home health services. The number of home health visits per beneficiary has increased. Seniors are spending less time in the hospital and more post-acute care, therefore, is rendered at home. There are more home health agencies providing services to beneficiaries, and there are also unexplained variations in the use and in the cost of services across the country, not always attributable to medical necessity.

The individuals who rely on this benefit tend to be in poor health relative to the overall Medicare population. Two-thirds of them are women. Half of these beneficiaries have incomes under $10,000 per year. While costs have increased dramatically, there's a clear need for these services among beneficiaries, and this need must be met. We should welcome what we have been able to do in the last 10 years in home health care.

For these reasons, I'm pleased the President's budget includes a number of important changes in Medicare's home health benefit—to reduce fraud and abuse within the program and to modernize the payment system. Many of these reforms, such as basing home health service payments on where the services are rendered, not where the billing offices are located, are long overdue. No longer will companies be reimbursed for the cost of labor based on wage rates in a large metropolitan area, when in fact the services were performed miles away in a low-cost rural area. This change alone over the next 5 years will save Medicare a billion dollars a year.

Further, the President's proposal will shift home health service reimbursement from a cost-based system to a prospective payment system. Most agree that a prospective payment system will allow us to limit costs and keep them more in line with actual utilization, while at the same time ensuring quality and access to medically necessary services.

Finally, there's been a great deal of controversy surrounding the President's recommendation that we shift a portion of the financing for home services from Part A to Part B of Medicare. Under the proposal, the first hundred visits following a 3-day hospitalization would continue to be covered under Part A, while all subsequent visits, including those not involving hospitalization, would now be reimbursed under Part B. This proposal would not only relieve pressure on the Part A trust fund until a bipartisan agreement can be reached to ensure the program's long-term solvency, but it's also consistent with the original intent of Part A which was designed to finance services more directly related to hospitalization. This provision, in fact, was supported by 228 of my Republican colleagues in October 1995, when the House passed H.R. 2485.

Having said that, I would like to welcome Dr. Bruce Vladeck again for being with us, also, William Scanlon, Donald Young, Margaret Cushman, and James Pyles for offering their insights into the Clinton Administration's reform proposal.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. And I thank you, Mr. Brown. Mr. Whitfield's on the telephone. Dr. Coburn, opening statement?

Mr. COBURN. Thank you, Mr. Chairman.

I just would want to emphasize how important home health care is in our country for a large number of people, and the original intention of this program and its goal are still prudent and worthy of us to continue this program and move it forward. There are a large number of problems with this program, based on incentives that were inadvertently put in the program. Through conversations, and I hope through testimony today, we're going to see how some of the incentives can be changed to, at the same time, cover those in our population that need homebound services, and at the same time continue to offer quality care for them.

So I look forward to our testimony. Thank you.

Mr. BILIRAKIS. Thank you, Doctor. Mr. Whitfield?

Mr. WHITFIELD. Mr. Chairman, I'm going to waive my opening statement.

Mr. BILIRAKIS. All right, thank you, sir. Let's see, I'm not sure—Dr. Ganske?

Mr. GANSKE. Thank you, Mr. Chairman.

I know that we have a long and distinguished group of witnesses, so I'll keep my comments brief. Like others on the panel, I have some serious concerns about the administration's proposal to shift $82 billion in home health care costs from Part A to Part B of the program. This may create some paper savings for the HI trust fund, but it doesn't really address the looming insolvency of Medicare. To solve the real problems facing our entitlement programs, we'll have to do more than simply move spending from one account to another. I look forward to a good dialog on this point, so we can better understand the reasons for the administration's proposal.

I also want to briefly mention two other issues. In a hearing last week, we had a good discussion of the AAPCC, the formula Medicare uses to pay HMOs. It's clear that some of the inequities in the AAPCC are the result of historic differences in utilization patterns. I'm interested in learning today how the move to a prospective payment system will affect areas in the country with different utilization patterns. I hope that it can be crafted in a way to reward those areas that have prudently held down both the amount and cost of home health services, instead of sealing in a reward for those areas of the country whose abuses led to the very need for a prospective payment system that we're talking about now.

Finally, let me also express some concerns about the administration's plan to establish guidelines on the number of visits for various conditions. While I agree that we need to examine why geographic variations in the number of home health visits for similar conditions, I have some real concerns about having the Federal Government establish practice standards on some very difficult scientific questions, and then having Congress become the health care arbiter in all of these areas. I think we need to be cautious in this area.

And I thank you, Mr. Chairman. I yield back my time.

Mr. BILIRAKIS. Thank you, sir. Mr. Burr?

Mr. BURR. Thank you, Mr. Chairman.

I commend Dr. Vladeck for having his testimony here, which is quite a feat. I appreciate that.

And I would also——

Mr. BILIRAKIS. An opt. note is the fact that you had that testimony with you last night and studied it well.

Mr. BURR. You may be intimidating the witness, Mr. Chairman.

Let me just say that I do want to make sure we stay focused on our understanding that, through this process, we want to do everything we can to extend the life of the trust fund, to make sure that this is the most cost-effective, quality-of-care-efficient system, delivery-of-health-care system that we can develop.

A tendency for knee-jerk fixes to meet a budget number are not in the long-term best interest of not only the system or of the patients. And I think for that reason it's very appropriate for us to delve into this as deeply as we can, Dr. Vladeck, and to make sure that, in fact, the suggestions this administration has as it relates to not only this portion of Medicare, but all the portions in fact have been well-thought-through, and that we can predict the outcome, because several times in your testimony you refer to the fact that throughout the eighties, as we did things, we did not predict well the effect that they would have. I hope that we have an opportunity to air the questions that we've all got with you, and that, in fact, you will share with us the valid answers.

I yield back, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

[Additional statements for the record follow:]

PREPARED STATEMENT OF HON. BRIAN BILBRAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, I want to thank you for conducting this hearing on Medicare Home Health Care. I look forward to hearing the testimony this morning on this program.

I commend the President for attempting to "balance the budget" in his Fiscal Year 1998 budget and to extend the solvency of Medicare Part A. However, I am concerned about his proposal to shift the majority of home health care provided under Medicare Part A to Part B.

Numerous individuals in the home health care field in my district have expressed their concern that this "solution" does not address the underlying problem, which is that the current reimbursement system rewards higher utilization and costs, and penalizes utilization control and cost effectiveness.

This shift takes the bulk of the home health benefit which the elderly have paid for with their payroll taxes while working and compels them to pay again with their premiums and general tax revenues which fund the Part B portion of Medicare. This is especially problematic for the elderly who are not currently enrolled in Part B. By building home health services into Part B, it appears that these beneficiaries would be compelled to pay Part B premiums in order to access the home health care which they now receive for free. The shift to Part B means that nearly 1.8 million seniors who only carry Part A coverage could lose their home care benefits. There might also be an attempt to impose the standard Part B 20 percent copayment on beneficiaries, which would hurt the elderly poor who constitute the bulk of home care services recipients.

In addition, "restoring the original intent" of the home health benefit by reinstating the three day hospital stay requirement before a beneficiary could utilize home care is problematic, due to the fact that home care is frequently in lieu of hospitalization, which is often more costly. Seventy percent of home health admission did not involve a prior hospitalization, which therefore makes the three day patient stay obsolete. Returning to the earliest days of Medicare does not make sense in this instance because home care is increasingly used to *prevent* hospitalization. This also poses a problem for the beneficiaries enrolled in a Medicare managed care plan because managed care encourages hospitals to discharge patients sooner rather than later. Medicare managed care patients who need home care may be discharged before the required three day hospital stay.

While it is duly noted that the President is attempting to slow the rate of growth of Medicare, and therefore extend the life of the program, I believe that some of the other proposals are more noteworthy than shifting home health care from Part A to Part B. Rather than regressing to an antiquated law by returning to the way Medicare was structured 30 years ago, I believe we need to move forward and take into consideration the advances in home care, as well as the needs of the elderly population.

Once again, Mr. Chairman, thank you for holding this hearing, and I yield back the balance of my time.

Mr. BILIRAKIS. Dr. Vladeck, I think I'll put you on for 10 minutes, if you will, please. Please proceed.

STATEMENT OF BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman, Mr. Brown, and members of the subcommittee. I appreciate the opportunity to appear here today and to be back with the members of the subcommittee.

I appreciate the remarks about the timely arrival of our testimony. I want to note that this is the result of some very hard work over weekend and evenings by a number of our staff and staff elsewhere, and I want to take the opportunity to publicly thank them. I also will note, without inference, that in contrast to my previous appearance before this subcommittee, when the testimony arrived much later, the earlier arrival of this testimony seems to be correlated with a much smaller turnout of members of the committee.

I will leave it to you to think about the cause-and-effect implications of that.

We are committed to improving the way we pay for home health services, and we very much look forward to working with the Congress on this effort this year. We are also taking a number of ad-

ministrative steps to reform the way in which we administer the Medicare home health care benefits, and I am pleased to discuss these as well.

As you know, it was a rather extensive written statement. There's a lot of material to cover. I will just try to highlight very briefly in my remarks this morning a few key points.

We began with a brief description of the benefit and evidence about its dramatic growth over the last decade. In particular, there was growth in the number of beneficiaries being served, the number of agencies providing services, and, most importantly, we believe from a policy point of view, the increasing number of visits per beneficiary served. I also pointed out in the testimony the dramatic variations in the use and cost of service across regions of the country, and even among States.

But, finally—and I very much appreciate that several of you made mention of this issue in your statements—my statement also referred to the chart. We have a larger version of that chart to my right this morning, which describes the characteristics of home health users as compared to other Medicare beneficiaries. It's fair to say that those who receive home health services are, indeed, poorer, older, and sicker than the typical beneficiaries. Whether or not these beneficiaries are receiving the appropriate services, whether in fact they are receiving the services that were defined in the definition of the benefit in the statute, there is no question that the overwhelming majority of Medicare beneficiaries who are receiving home health services are frail people with significant health problems and with limited other supports in the community. They are in need of some kind of help and some kinds of assistance, and we need to keep that in mind as we seek to reform this benefit.

Mr. Burr just made reference to the issue of unintended consequences of early policy changes. In the written testimony we go into a fuller analysis of all the contributing factors for the enormous growth in utilization, including the demographics, the changes in medical technology, and the increase in sophistication on the part of providers.

Let me just spend a few moments on this unintended consequence issue by describing, in some detail, the 1980 OBRA legislation that we believe, in some ways, set the framework the phenomena that we are currently trying to address. For the first 15 years of the Medicare program, there were two distinct home health benefits: a post-hospital home health benefit under Part A of the program and a community-based home health benefit under Part B. When Medicare was first created in 1965, Part A, as financed through the hospital insurance trust fund, was designed to cover only hospitalizations and short-term recuperative post-acute care either in a skilled nursing facility or extended care facility, in the terminology then used, or in the home. The Part A home care benefit was limited to 100 visits for beneficiaries immediately following their discharge from the hospital with a minimum stay of 3 days. There is no beneficiary cost-sharing for this Part A benefit.

The Part B benefit did not have a post-acute focus, and, as such, did not have a hospital stay requirement. It was also limited to 100 visits during a calendar year. The Part B deductible applied to the

Part B home health benefit, but after 1973 beneficiaries were no longer required to pay co-insurance for Part B benefits.

In OBRA 1980, Congress eliminated the 3-day prior hospitalization requirement under Part A, eliminated the 100 visit limits for both Part A and Part B, eliminated the deductible for home health services under Part B, and permitted a much broader range of agencies, including for-profit agencies, to participate in the Medicare program. In effect, OBRA 1980 transformed the home health benefit into an unlimited benefit, one that serves chronic long-term care needs of patients, as well as the needs of those who require more short-term recuperative care immediately following a hospital stay.

Because Part B home health benefits are now used only by the very small group of beneficiaries who are not enrolled in Part A, the OBRA 1980 change had the unintended result of burdening the HI trust fund with financing approximately 99 percent of all Medicare-paid home care, regardless of whether or not visits are related to a hospitalization. That's the problem we are seeking to fix in our budget proposal.

Some of the other growth in the home health benefit is due to the current law's loopholes, which make it very difficult to define with sufficient clarity what is covered and who is eligible for coverage; for example, what terms such as "homebound" mean. We have a number of legislative proposals in the budget to try to clarify and address some of these statutory concerns.

These proposals are very closely rooted in the successes of our anti-fraud initiatives in the Medicare Home Health Initiative and Operation Restore Trust. In addition to the greater detail in my written statement, the Department's Inspector General will be testifying today on some of what we've learned in these activities.

More generally, we're not waiting for legislation to try to get a better handle on the growth in Medicare home health expenditures. HCFA is pursuing a variety of administrative reforms to curb unnecessary utilization, to stop fraudulent billing, and to improve the quality of services. These initiatives include the following:

First, I am pleased to announce that today we are putting on public display, pending publication in The Federal Register later this week, revised health and safety standards for home health agencies. Our revised conditions of participation are being published in conjunction with proposed rules for patient assessment through the introduction of the Outcomes and Assessment Standard Information Set, or OASIS. And, together, these rules will hold agencies accountable for better, more accurate patient assessment, care planning, coordination of service delivery, quality assessment, and performance improvement.

The introduction of the OASIS dataset will permit agencies to systematically assess patients, to improve patient outcomes, and to allow physicians, agency providers, and patients to make more appropriate treatment decisions. It will also provide us with the backbone and the framework of data necessary to develop a sophisticated prospective payment system for home health agencies. This is because OASIS contains the kind of information we will need to adjust prospective payments to account for real differences in case mix.

On the administrative front as well, we've embarked on a national expansion of the survey efforts we undertook under Operation Restore Trust. These are surveys of agencies for which allegations of questionable activities have been received or where there are concerns about their patterns in Medicare billing. These surveys represent the first systematic effort to share information between our regional home health intermediaries and the State surveyors.

Finally, we are in the process of a number of educational outreach efforts to teach both beneficiaries and ordering physicians about the home health benefit and how to detect and report variances or fraudulent practices. We are gradually implementing delivery of a notice of service even when the beneficiary has no outpatient liability. All beneficiaries for whom we've been billed for Medicare-paid home care will receive notices describing what we have been billed for, so that they can report discrepancies between the service billed and the services they received.

Before I turn to our legislative proposals to reform the benefit, allow me to point out that my written statement contains a somewhat broader context in terms of our vision of a future integrated payment system for all post-acute Medicare services. It's in the context of that vision that we believe, over time, we can move toward a single payment system for home health agencies, skilled nursing facilities, and other Medicare post-acute benefits.

We believe that it's critical to implement a prospective payment system for home health care as soon as we have available a defensible and empirically valid system, and we want to work closely with the Congress to ensure that this takes place. A sufficiently sophisticated and validated system will provide incentives to agencies to make the most appropriate use of resources. In the long run, such a system will help us control overall expenditures, and it will help us monitor the quality of care more effectively.

We're developing such a system as fast as we can through a broad range of demonstration and research activities, much of which will depend on the availability of the OASIS data. We're confident that we will be ready within about 30 months to implement a case mix adjuster that will provide home health agencies with the right incentives to provide the appropriate level of services. This case mix adjuster will measure resource use differences among patients and across agencies all across the country.

The second chart summarizes the whole range of our other legislative proposals, but let me just say one more word about prospective payment systems. Having lived firsthand through the implementation of hospital-based prospective payment, first in the State of New Jersey and then nationally in the Medicare program, I would just say that there is something worse than maintaining cost-based reimbursement, and that is premature adoption of a case mix system based on inadequate case mix measures.

My time having expired, Mr. Chairman, despite the deathless words that I would have provided in the balance of my statement, I'll stop here and I'm happy to respond to any questions anyone might have.

[The prepared statement of Bruce C. Vladeck follows:]

PREPARED STATEMENT OF BRUCE. C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

REFORMING THE MEDICARE HOME HEALTH BENEFIT

Introduction

Thank you, Mr. Chairman, for the opportunity to testify today. I am pleased to discuss the Medicare home health benefit and the Administration's efforts to reform the benefit. The Administration is committed to reforming the way we pay for home health services and we look forward to working with the Congress on these reforms. The Administration is also taking a number of administrative steps to reform the benefit and I am pleased to discuss these as well.

Description of the Benefit

Under the home health benefit, Medicare pays for skilled health care and other services related to the treatment of an illness or injury. To receive home health care, a beneficiary must be under the care of a physician who has determined that medical care in the home is necessary and who has prepared a plan of care. Furthermore, the beneficiary must be confined to the home and must need intermittent skilled nursing care, or physical therapy or speech language pathology services. Finally, care must be provided by a Medicare-certified home health agency (HHA). If these requirements are met, Medicare will pay for:

Skilled nursing care, either on an intermittent or part-time basis, but not full-time. Skilled nursing care includes skilled observation and assessment, administration of medications, wound care, ostomy care, venipuncture, and other services performed by licensed nurses.

Physical therapy, occupational therapy, and speech language pathology, for as long as they are medically necessary and reasonable. These services help beneficiaries restore movement and muscle strength, achieve independence in daily living, and restore speech.

Medical social services, to assess the social and emotional factors related to the illness and to search for available community resources.

Home health aide services, either on a part-time or intermittent basis, but not full-time. These services include assistance with personal care (such as feeding, bathing, using the toilet, or dressing) and routine care of prosthetic and orthotic devices. Medicare does not pay for personal care if it is the only care that the beneficiary needs. Medicare also does not pay for homemaker services such as shopping, cleaning, and laundry.

Medical supplies, like wound dressings, braces, blood drawing and intravenous supplies.

Durable medical equipment, like wheelchairs, walkers, and oxygen equipment. For DME, beneficiaries must pay the 20 percent Part B coinsurance.

Other than for DME supplies, there is no beneficiary co-insurance.

As expected, Medicare beneficiaries using home health services tend to be in poorer health than the general Medicare population (see chart). Two-thirds are women, and one-third live alone. Forty-three percent have incomes under $10,000 per year.

Growth in Expenditures and Utilization

Expenditures for home health services are one of the fastest growing components of Medicare. Expenditure growth is due to the increase in the number of visits per beneficiary (intensity), the growth in the number of beneficiaries using home health services, and the growth in the number of HHAs serving beneficiaries.

In terms of intensity growth, consider that in 1980, the average home health beneficiary used 22 visits. This number grew to 33 visits in 1990, and about 76 visits per user for 1996.

In terms of growth in the number of beneficiaries using the benefit, in 1980, 700,000 Medicare beneficiaries used the benefit. By 1990, 1.9 million, or 5.6 percent, of Medicare beneficiaries had received home health services. This has increased to about 3.7 million, or 10.1 percent of beneficiaries, in 1996.

Finally, the number of HHAs participating in Medicare has grown from 3,125 in 1982 to 5,656 in 1990, to over 9,800 in 1996.

We have also seen that there is a dramatic variation in the use and cost of services across regions of the country and even among States. For example, in 1994 the average number of visits per beneficiary was 126 in Louisiana, 76 in neighboring Arkansas and in Florida, 97 in Texas, 45 in New York, 46 in California, and 40 in Oregon. The national average visits per user in 1994 was 66. Expenditures per person served vary widely, too. The national average program payments per home

health user in 1994 was $4,016. Compare this to $6,700 in Louisiana, $4,595 in Florida, $3,334 in New York, and $3,118 in Oregon.

Reasons for Expenditure and Utilization Growth

The dramatic increase in utilization and expenditures for home health is due to a number of factors, including policy changes, changing demographics, medical advances, and increases in demand by beneficiaries and physicians. With respect to policy changes, some had unintended consequences. While they were often undertaken with the belief that they would reduce total costs by shifting resource use from more expensive (hospital) to less expensive (post-acute care) settings, for the most part, these policy changes were not systematic attempts to reform Medicare. Rather, they occurred piecemeal throughout the years to achieve specific objectives. And, they may not have resulted in a reduction in total Medicare costs.

OBRA 1980 Liberalization—For the first fifteen years of the Medicare program, there were two distinct home health benefits: a post-hospital home health benefit under Part A of the program, and a general home health benefit under Part B. When Medicare was created in 1965, Part A (financed by the Hospital Insurance, or HI Trust Fund) was designed to cover only hospitalizations and short-term, recuperative, post-acute care in the home or other facilities. The coverage and eligibility rules of the post-hospital home health benefit reflected this emphasis. The Part A benefit was limited to 100 visits available to those beneficiaries who were discharged from a hospital following a minimum 3-day stay. There was no beneficiary cost-sharing for the Part A benefit. The Part B benefit did not have a post-acute care focus and as such did not have a hospital stay requirement. It covered 100 visits during a calendar year. The Part B deductible applied to the Part B home health benefit and, until 1973, beneficiaries were required to pay coinsurance for their Part B visits.

In the Omnibus Budget Reconciliation Act of 1980 (OBRA 1980), Congress eliminated the 3-day prior hospitalization requirement under Part A, eliminated the 100-visit limits for both Part A and Part B, eliminated the deductible for home health services under Part B, and permitted proprietary HHAs to receive Medicare payments.

In effect, OBRA 1980 transformed the home health benefit into an unlimited benefit—one that serves the chronic needs of patients as well as the needs of those who require more short-term, recuperative care after a hospital visit. Because Part B home health services are only used now by that small group of beneficiaries who are not enrolled in Part A, the OBRA 1980 change had the unintended result of burdening the HI Trust Fund with financing approximately 99 percent of the home health benefit, regardless of whether visits are related to a hospital stay. As you are aware, this is a problem we seek to fix in our legislative proposals.

OBRA 1980 also allowed for Medicare certification of proprietary home health agencies. Payment to proprietary agencies—which now represent 48 percent of all certified agencies—are the fastest growing segment of Medicare home health expenditures. One analysis suggests that beneficiaries receiving care from proprietary HHAs receive 21 more visits, on average, than those receiving care from non-profit agencies, even after controlling for the differences in health and functional status of the beneficiary, as well as age, sex, and living situation.

Duggan v. Bowen—In the early 1980s, HCFA attempted to control excessive growth in utilization through enhanced review of claims, more detailed reporting, and other measures. However, these attempts were thwarted by a 1988 court case, *Duggan v. Bowen,* the settlement of which resulted in a re-interpretation of the "part-time or intermittent" eligibility criteria in a way that vastly expanded the benefit's coverage. The impact of the *Duggan* settlement, on top of the OBRA 1980 changes, had a dramatic impact on home health utilization, as noted by the General Accounting Office (GAO) in its March 1996 report on Medicare Home Health Growth (GAO/HEHS-96-16).

In the aggregate, as a result of the OBRA 1980 changes and the *Duggan* settlement, we have witnessed a steady growth in the number of home health visits per user and the number of users. Much of the growth in home health outlays is due to patients who receive more than 100 visits per year. The *Duggan* settlement has been the catalyst for a 38 percent annual increase in home health expenditures from 1988 to 1992, and a 167 percent increase in visits per beneficiary from 1989 to 1995.

Impact of Hospital PPS—The implementation of the Prospective Payment System (PPS) for inpatient hospitals also resulted in increased utilization of post-acute services such as home health, skilled nursing facility services (SNFs), and rehabilitation services. Hospital PPS provides payment to hospitals on the basis of diagnosis rather than the actual costs incurred by the hospital in providing care to each patient. Hospitals responded to the incentives in PPS by, among other things, shortening the

lengths of stay. Patients were discharged earlier, with less complete recovery, resulting in increased use of post-acute services. There has been a significant shift in Medicare spending from PPS hospitals to post-acute providers such as home health agencies. In 1986, acute care hospitals received more than 91 percent of Medicare Part A payments whereas post-acute care providers received less than 9 percent of Part A payments, with HHAs receiving 4 percent. In 1993, however, the percentage of Part A payments to hospitals decreased to less than 74 percent in 1993, while payments to post-acute care providers increased to more than 26 percent, including 10.5 percent to HHAs.

Changing Demographics, Medical Advances, and Increases in Patient Demand—Changing demographics, medical advances, and increases in demand by beneficiaries and physicians have all contributed to increasing expenditures. Medical advances, for example, have expanded the range of patients who can benefit from certain therapies, and have made it possible to provide interventions (such as intravenous drug therapy) in the home. Certainly, shifts in demographics have had an immense impact on the use of post-acute and long-term care services. Studies show that home health care is serving many more of the older elderly population who require longer term care. Physicians and beneficiaries are increasingly showing a preference for home health care over other modalities. In addition, HHAs are now aggressively marketing their services to physicians to stimulate demand.

Fraudulent, Abusive, and Wasteful Practices—Our review of the supporting documentation for claims from some HHAs has revealed alarming instances in which Medicare was billed for unnecessary or inappropriate. The Medicare claim "error rate" was high as 75 percent in the case of one agency in Florida; that means that 75 percent of the claims for that agency should not have been paid. Other HHAs have had high error rates as well, and about a quarter of claims from the industry overall seem to be inappropriate.

Most of the erroneous claims are for care that simply is not necessary—that occur solely for the purpose of earning money for the agency. Other erroneous claims are for services that are not furnished at all or for beneficiaries who were not homebound. In addition, there were significant numbers of instances in which the services were never ordered by a physician, or where physician orders were forged. Finally, when there were physician plans of care for Medicare beneficiaries, in too many instances the care that the beneficiary received was different from that necessary for their recovery. As serious as it is to provide unnecessary services, it is even more serious to fail to provide services that are necessary.

While we do not want to discourage appropriate use of the benefit, we simply cannot afford to tolerate the fraudulent and abusive practices that exist in some parts of this industry. Current law contains loopholes whereby providers can be paid excessive amounts. As I'll describe later, we have several legislative proposals in the President's budget to close these loopholes. These legislative proposals build on the successes of our anti-fraud initiatives such as Operation Restore Trust (ORT) and the Medicare Home Health Initiative.

HCFA Administrative Efforts to Stem the Growth of Inappropriate Utilization and Costs

I want to reassure the Congress that HCFA has intervened where possible to stem the growth of inappropriate utilization. I want to describe in some detail efforts we have undertaken, or are undertaking, to address this concern.

Almost four years ago, I commissioned the Medicare Home Health Initiative, an agency-wide, comprehensive assessment of the home health care benefit. The Initiative involved consultation with representatives from consumer groups, the home health industry, professional organizations, fiscal intermediaries, and State agencies. The Initiative has spawned various efforts to make a number of improvements to the benefit and, where possible, assert greater control over inappropriate utilization.

Conditions of Participation and OASIS—As you are probably aware, we will soon publish revisions to the Medicare Conditions of Participation (CoPs) for HHAs and a requirement that HHAs collect information relating to an Outcomes and Assessment Standard Information Set (OASIS). In tandem, these rules will hold HHAs accountable for better, more accurate patient assessment, care planning, coordination of service delivery, and quality assessment and performance improvement. Among other things, these rules would require agencies to:

- Systematically assess patients to improve patient outcomes and to allow the physician, agency practitioners, and the patient to make more appropriate clinical treatment decisions. This OASIS data must be routinely collected and analyzed by each HHA. This assessment data will form the basis of our ability to monitor individual agencies' overall quality performance, focus external survey efforts on

the detection of instances where patients may be receiving fewer or more visits than necessary to achieve expected outcomes, and foster improved home health care outcomes nationally.

- Implement quality assessment and performance improvement programs. The proposed rule would raise the performance expectations for agencies by requiring them to develop, implement, and maintain a data-driven continuous quality review and performance improvement program.
- Improve care planning and coordination of services to reduce redundant or conflicting treatments, eliminate confusion for the patient, and generally improve the level of care.
- Safeguard continuity of care by holding agencies responsible for the interdisciplinary coordination and provision of all services ordered under that patients's physician-prescribed plan of care. This standard addresses a current problem in which an agency may treat a patient for only specific services and then refer that patient to several other agencies for the remainder of the treatment.
- Strengthen patient rights protections and add to the current protections by requiring agencies to (1) provide patients in advance with more detailed information on the care and treatment to be provided, and (2) inform patients about expected outcomes and any barriers to treatment.
- Require that a majority of services (nursing, therapy, social work and home health aide) services furnished to home health patients be provided directly by staff employed by the HHA, rather than by contracted personnel. This reflects HCFA's belief that excessive use of contracted personnel may indicate that an agency is not exercising the appropriate level of control over quality of care, or that an agency may be exceeding its patient capacity. This standard would also better ensure coordination of care and care planning.

Revised HHA Manual—We also recently overhauled our provider manual to provide better guidance to agencies on the complex home health eligibility and coverage rules. We expect this greater clarification to reduce the amount of inappropriately furnished services that are billed to Medicare.

Physician Outreach—We have also worked to increase physician involvement in the monitoring of home care services. Physician involvement in care plan oversight is critical to ensure that the appropriate level of care is being provided. We need to avoid situations in which physician certification is merely a rubber stamp of a plan of care that has been completed by a home health agency. HCFA is now reimbursing physicians for care plan oversight to engage physicians in the careful planning of home care services. We are also involved in a number of efforts to educate physicians about the home care benefit. For example, HCFA has developed home health public service announcements and other materials to educate physicians and their staffs regarding developing a plan or care, monitoring patient progress, and detecting fraud and abuse.

Beneficiary Outreach—We are better educating beneficiaries about the home health benefit in an effort to help them recognize instances of inappropriate care or fraud and abuse. We have published a new home health brochure and have produced a video that is shown in hospital and office settings. This year, we began sending Notice of Utilization statements (NOUs) to beneficiaries to inform them of the services being billed on their behalf so that they can detect any aberrancies.

Operation Restore Trust (ORT) Initiatives—In May 1995, President Clinton and Secretary Shalala launched ORT to improve efforts at detecting and eliminating Medicare and Medicaid fraud, waste, and abuse. ORT is targeting four areas of high spending growth, including home health care, in the five Sates that comprise more than one-third of all Medicare and Medicaid beneficiaries—New York, Florida, Illinois, Texas, and California. ORT has provided additional funding to allow for enhanced surveys on facilities for which allegations of questionable activities have been received or that may have inappropriately billed Medicare.

These enhanced ORT surveys facilitate the sharing of information between regional home health intermediaries (RHHIs) and surveyors. Because surveyors make onsite visits to home health agencies and to beneficiaries receiving services, they can identify information that can assist an RHHI in making determinations about the appropriateness of claims. State survey agencies are asked to identify and gather information on behalf of RHHIs concerning the homebound status of beneficiaries, home health services billed but not rendered, and inappropriate billing of supplies. HCFA has learned that often where there is fraudulent billing, there are also quality deficiencies. Thus, the information from the RHHI helps the surveyors focus on providers who are more likely to be delivering substandard care or otherwise failing to meet CoPs. HCFA will be continuing to encourage the collaboration between RHHIs and State survey agencies teams and expand this survey process to other States.

We will continue our diligence in attempting to stem the tide of inappropriate home health utilization. As the GAO noted in its March 1996 report on Medicare home health growth, HCFA is working to gain greater control over the use of the home health benefit.

Legislative Proposals

The Broader Context for Payment Reform: An Integrated Payment System—Before I delve into the specific legislative proposals, I want to emphasize that our HHA payment proposal should be viewed as an interim step to an integrated payment system for post-acute services. Many argue that the post-acute care payment system of the future must be one that provides comparable incentives across delivery sites. While we will not stop our efforts to develop a prospective payment system for HHAs and another for SNFs, we should not be permanently wedded to separate payment systems for each of the self-contained post-acute care benefits. Rather, we should strive to better understand the value of each post-acute care provider type and how to better manage and coordinate care across the health care continuum.

Payment reform should ultimately support an infrastructure of post-acute and long-term care delivery systems that is better integrated and more flexible in meeting the needs of those with chronic conditions and disabilities. That is, a guiding principle in any lasting reform of the Medicare post-acute care benefits should be to make the system of services "beneficiary-centered." To be beneficiary-centered, an integrated delivery system needs a reliable and predictable stream of financing. It also requires a system of maintaining information on clients that is consistent and available to all service providers. This kind of information is essential as we work to target funds and determine how we go about fairly and accurately assessing what kind of care someone needs. Beneficiary-centered services also rely on inter-disciplinary case management that involves formal and informal caregivers and supports and encourages, where appropriate, beneficiaries to direct their own care. Finally, a beneficiary-centered system needs relatively standardized service packages typically provided by various health care professionals.

There is considerable overlap in the types of services provided and the types of beneficiaries that are treated in each of the post-acute settings. These distinctions are becoming increasingly blurred with advancing technology. For example, physical therapy and other rehabilitation services can be provided in each of the settings. A recent HCFA analysis shows that 53 percent of beneficiaries treated in the hospital for hip fracture use SNF services, 14 percent use home health services, and 14 percent use rehabilitation hospital services. Similarly, 25 percent of patients treated in the hospital for stroke use SNF services, 26 percent use home health services, and 16 percent use rehabilitation hospital services. While there may be some clinical differences in the patients who go to each of these settings and in the outcomes as a result of care provided in each of these settings, it is also likely that patient and physician preferences influence which type of post-acute service is used.

Despite the considerable overlap, Medicare's payment and coverage rules vary by setting. While I don't wish to discount the importance of beneficiary preference in making these decisions, I would like to ensure that Medicare payment is not the primary reason for care setting decisions. Medicare payment methods and amounts for similar services provided in each of the post-acute settings differ. And more expensive stays do not always imply more services or better outcomes. For example, some provocative early research findings suggest that, for some conditions, outcomes may be no better for beneficiaries treated in one setting than another, even though Medicare payment may be substantially different. I am hopeful that further research into the characteristics of patients that use care in each of the post-acute settings, and an analysis of outcomes, can provide information about the most appropriate setting for different types of patients.

As I've suggested, any effort to control the utilization of post-acute care services and ensure equity and appropriateness of payment must involve a mechanism to track outcomes and services that address patient care needs. Such a mechanism ideally begins with a valid and reliable assessment screening instrument that would provide a preliminary assessment of the patient's needs and the types of services that would best meet desired health outcomes at the lowest possible cost. This type of instrument could also be used to assess the individual's values and preferences for continuing care, so that if two or more types of care would typically provide the desired outcomes at comparable costs, the individual could choose the type of care he or she would receive under Medicare. Such an assessment instrument should also be made up of core data elements (e.g., functional status, available care supports, etc.) that would be relevant across the care continuum and that would support case-mix payment systems.

As you may be aware, HCFA has been developing assessment instruments—the Uniform Needs Assessment Instrument (UNAI), the long-term care facility minimum data set (MDS), and, of course, the OASIS for home care. The next challenge is to identify common elements among the instruments to support an integrated payment system.

Under a possible future payment scenario, we would want to provide payments sufficient to ensure that beneficiaries receive high quality care in the appropriate settings, and that any transfers among settings occur only when medically appropriate and not in an effort to generate additional revenues.

In an effort to make payment systems "site-neutral," we might also consider splitting apart payment of the "medical" services from the room and board services. That way, payment for the "medical" services can be the same for similar patients regardless of whether they are delivered in the home or in a nursing facility. This would help address problems related to the institutional bias as well as clarify the allocation of responsibilities between Medicare and Medicaid.

This discussion addressed our general direction regarding the future of post-acute care payments. My message is that we are thinking more broadly about an integrated reimbursement system for post-acute services even as we focus our attention on developing a prospective payment systems for HHAs.

Status of PPS Demonstration and Studies

We believe that it is critical to embark on a prospective payment system for home health care as soon as it is viable, and we are committed to working with Congress to design a prospective payment system that controls costs and also ensures quality and access. An empirically valid and reliable PPS will provide incentives to HHAs to make the most appropriate use of resources and, in the long term, will help control overall expenditures.

We have dedicated many resources toward developing a prospective payment system for HHAs. In fact, we are in the process of testing a prospective payment system through the National Home Health Agency Prospective Payment Demonstration. Demonstrations are very useful in testing the appropriateness of specific payment methodologies in advance of full implementation. They are also very useful in identifying methods that do not work well, and that we would not want to implement.

PPS Demonstration—The National Home Health Agency Prospective Payment Demonstration is testing two alternative methods of prospective payment. Phase I of the demonstration tested a per-visit prospective payment. Phase II of the demonstration, which began in June 1995, is testing a per-episode prospective payment, and will last for two more years.

In Phase I, we tested a per-visit payment method that established a separate payment rate for each of six types of home health visits (i.e., skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services), and found that this methodology is not effective in controlling home health expenditure growth.

In Phase II, we are examining the effect of an episode payment on spending, the number and types of visits provided, and quality of care. Participating HHAs are receiving an agency-specific episode payment based on 120 days of care and outlier payments for episodes that extend beyond 120 days. The prospective rates are based on an agency's costs in a base year, and are case-mix adjusted. Outlier visits are reimbursed at per-visit prospective rates. A new episode of care does not begin until there has been a gap in home health services for 45 or more days after the initial 120 days. Agencies receiving per-episode payments are subject to stop-loss and profit sharing provisions.

We do not yet have results from this phase of the demonstration. While we do not yet have an appropriate definition of an episode, we do know that we have concerns about a system based on a 120-day episode with all visits after 120 days paid as outliers. Outliers should represent unusual cases, not the norm. The integrity of a prospective payment system is violated if almost half of all visits are classified and paid as outliers. Consequently, we are continuing to explore through research the appropriate unit of payment and episode length.

Case-Mix Project—The case-mix adjuster used in the demonstration was developed to reflect case-mix changes within an agency from year to year, not across agencies. In any prospective payment system that we implement nationally, we would want a case-mix adjuster to differentiate case-mix across HHAs. We are currently funding a project that will lead to this type of a case-mix adjuster. This research will examine the relationship between patient characteristics and home health resource use and develop a case-mix adjustment system for our PPS system. This research will utilize the information on patient characteristics included in OASIS that all HHAs

will be required to complete. Agency recruitment will begin shortly, and data collection will begin in the Fall of this year. Data collection will continue through October 1998 and analysis will take place through the end of 1998.

Volume-Outcome Study—Developing a prospective payment system is further complicated by the wide variation in the number of home health visits provided per home health user. In setting payment rate for a prospective payment system, it is important to know, within a range, what the appropriate amount of care is needed to produce the best possible patient outcomes. If HHAs are currently over or under providing home health care, we do not want to create incentives in a prospective payment system that continue the current utilization patterns. HCFA is sponsoring a study to examine the relationship between the volume of home health services received and patient outcomes. If this study is able to identify thresholds below and above which home health does not contribute to better outcomes, this might help us develop a prospective payment system that reflects the level of care that should be provided to produce the best possible patient outcomes.

The information we have gained from the demonstrations thus far laid the foundation for the payment proposals that are included in the President's FY 1998 budget submission.

FY 1998 Legislative Proposals

We proposed a number of home health payment reforms designed to achieve needed cost control, improve financial management, and control fraud and abuse. We have proposed interim payment controls until we can transition into a PPS in 1999.

National Prospective Payment System—There is broad agreement among industry representatives, and members of Congress, that a prospective payment system is the superior way to constrain costs without sacrificing access or quality. We have sketched out in our legislation some of the features that are desirable for such a system. The essence of any prospective payment system is the unit of payment and case-mix adjustments. The unit of payment for a home health prospective payment system would need to be clearly defined. An appropriate case-mix adjuster that explains a significant amount of the variation in cost is also essential. In order to prevent un-bundling, we would anticipate that the prospective rate would cover all services currently covered and paid on a reasonable costs basis under the Medicare home health benefit, including medical supplies.

The prospective payment amount would be adjusted annually by the HHA market basket index. The labor portion of the prospective payment amount would be adjusted for geographic differences in labor-related costs based on the most current hospital wage index. The Secretary would have the authority to establish a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care. Finally, if a beneficiary elects to transfer to, or receive services from, another HHA, we would prorate the payment.

We are committed to implementing a prospective payment system for home health as soon as possible. There is, however, critical work remaining to be done before we can implement such a system—namely, the development of a case-mix adjuster that can explain a significant amount of variation in costs per case, and the development of an appropriate unit of payment. Our legislative proposal seeks authority for the Secretary to implement a prospective system that meets these parameters. However, since many key elements are still in development, we do not believe that we can specify them in statute at this point. Our legislative proposal seeks authority to request data from HHAs to support our continued development of the prospective payment system.

Interim Payment System—While we continue to develop these essential features of a PPS system, we propose to implement some interim changes to our existing payment system that would allow us to achieve additional cost control. The Administration's proposal would rely on proven techniques of cost limit reductions to achieve guaranteed, up-front savings without disrupting the industry with a host of new payment methods.

In the interim, we would establish a new cost limit on top of the existing cost-based reimbursement. This new cost limit would build on agencies' actual experience in resource use per beneficiary in a base year. This cap on historical utilization or intensity per beneficiary will contribute to expenditure control during the time span of the interim system. The cap would give agencies the flexibility to provide the appropriate amount of care (duration of visits, number of visits, and skill level of caregiver) within this limit.

To be more specific, payment to an HHA would be the lesser of: (1) the agency's actual costs, or (2) a per visit cost limit set at 105 percent of the median national cost for free-standing HHAs, or (3) this new agency-specific per beneficiary annual

limit. This proposal can be implemented immediately, with few administrative changes and little additional administrative burden on home health agencies, and allow for a sensible phase-in to a prospective payment system.

You may ask why we would continue with a cost-based reimbursement system at all in the face of comments that a prospective payment system is preferable. First, as I've explained earlier, we simply will not have all of the necessary ingredients for a prospective payment system ready until October of 1999. Second, we can guarantee that the modification to the cost limit and the introduction of a per beneficiary cap will achieve scorable savings immediately upon implementation. We cannot make that assertion about any other system currently being discussed.

Finally, I ask you to consider this: at a rhetorical level, it is easy for some to state that cost-based reimbursement is inherently bad (because it provides incentives to increase costs up to the statutory limit) and that a prospective payment system in inherently good. We need more time to develop a prospective payment system that contains a reliable case-mix adjuster to protect beneficiaries against cream-skimming and under-service. A good prospective payment system is better that a cost-based system, but a cost-based system is certainly better than a poorly designed prospective payment system without an appropriate case-mix adjuster.

In addition to our payment proposals, we have a number of proposals designed to close existing loopholes for inappropriate billing and payments.

Eliminate PIP Payments—We propose to eliminate periodic interim payments (PIP) for HHAs simultaneous with PPS implementation in 1999. PIP was established to encourage new providers to participate in Medicare by improving cash flow by paying a set amount on a bi-weekly basis. However, with about 100 new HHAs joining Medicare each month, access to home health is no longer a problem. Further, the Office of the Inspector General has found that Medicare tends to overpay providers who receive PIP, and has validated our contention that it is sometimes difficult to recover these overpayments.

Payment at Location of Service—We propose to base payments on the location where services are rendered, not where services are billed. Many HHAs are established with a parent office in an urban area and branches in rural areas. When these HHAs bill Medicare, the payment is based on the higher wage rate for the urban area even though the service delivery occurred in a lower-cost rural area.

Clarify the Definition of "Homebound"—We also propose to clarify the "homebound" definition by adding several calendar month benchmarks to emphasize that home health coverage is only available to those who are truly unable to leave the home. The current statutory definition is vague and overly broad. It allows for considerable discretion in interpretation, and for waste, fraud, and abuse. Financial reviews show that Medicare routinely reimburses care to beneficiaries who are not truly homebound. Without a more concrete definition, this eligibility requirement is very difficult to enforce. The March 1996 GAO report cites the problematic homebound definition as contributing to excessive spending and fraud and abuse.

Provide Secretarial Authority to Make Payment Denials Based on Normative Service Standards—We also seek the authority to work with the health care community to establish normative numbers of visits for specific conditions or situations. For example, HCFA could establish a normative number of aide visits for a particular condition, and deny payment for those visits that exceed this standard. Allowing the Secretary to establish more objective criteria will help HCFA gain more control over excessive utilization. The March 1996 GAO report criticizes current statutory coverage criteria as leaving too much room for interpretation and inviting fraud and abuse.

Restore Post-Hospital Home Health Benefit Under Part A and Reallocate Other Home Health Services to Part B—I know you are aware of our proposal to reallocate financing of a portion of the home health benefit from Part A to Part B. Under our proposal, the first 100 home health visits following a three-day hospital stay would be reimbursed under Medicare Part A. All other visits, including those not following a hospitalization, would be reimbursed under Part B. Part B visits would not be subject to the Part B coinsurance or deductible. The transfer would not affect the Part B premium.

Clearly, by limiting Part A financing of the home health benefit, we would be saving the financially vulnerable HI Trust Fund about $80 billion over 5 years. This is an important motive, and I note that Republican members voted to achieve the same goal with a similar technique. An unintended consequence of the OBRA 1980 change was to burden the Part A Trust Fund with approximately 99 percent of the financing for the home health benefit, regardless of whether or not visits are related to a hospital stay. The huge shift in financing to Part A clearly was not consistent with the original intent of Part A, the Hospital Insurance Trust Fund, which was designed to only finance services that centered around a hospitalization.

We deliberately excluded the impact of this Part B financing from the calculation of the Part B premium. We are concerned about the impact that higher beneficiary out-of-pocket expenses would have on poorer Medicare beneficiaries. Currently, Medicare beneficiaries spend an average of $2,605 on out-of-pocket health expenditures; this accounts for 21 percent of family income of Medicare beneficiaries. Poorer beneficiaries spend a greater proportion of their income on out-of-pocket costs.

Comparison with Industry Proposal

We have heard some criticism about our approach of continuing cost-based payment until we have an adequate case-mix adjuster to use in a prospective payment system. The industry has offered an alternative proposal that moves to prospective rates sooner. Let me take this opportunity to highlight some of our concerns about moving too quickly to a prospective payment system which we think contains a number of flaws that could damage beneficiary access to service and result in increased expenditures (rather than expenditure control).

One concern is that the proposal would force us to use the 18-category patient classification system from our Phase II demonstration as a means to case-mix adjust a 120-day episodic expenditure cap. As I described before, the demonstration's classification scheme was designed merely to measure resource intensity changes from one year to another within an individual agency. It was not designed nor intended to measure resource-use differences among all home health patients and across all agencies in the country, and it would perform poorly in this manner. Moreover, the classification scheme explains less than 10 percent of the variation in costs—far less than the initial DRG system for hospitals. We have research underway to develop a case-mix measure to adjust payment rates for our PPS. The development of a case-mix adjuster to adjust an expenditure cap would require additional research.

Some would want you to believe that it is better to implement a bad PPS system now rather than wait for a valid and reliable system in two years from now. We are convinced that savings cannot be guaranteed under an untested, unreliable new payment methodology that uses an inappropriate case-mix adjuster.

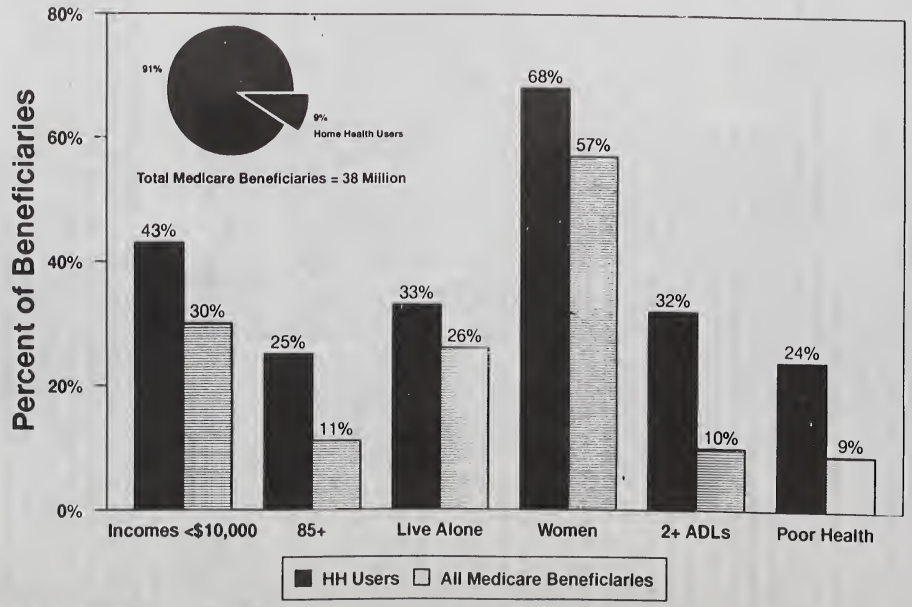
Another concern about the industry proposal is that it would pay per-visit rates subject to a 120-day expenditure cap. As I already mentioned, results from our demonstration show that per-visit rates do not hold down Medicare costs. As to the 120-day episodic cap, I have already mentioned our concerns about using a 120-day unit of payment since about 40 percent of all home health visits would fall outside of this cap.

As a concluding note, I should add that making huge changes to our current payment system in the interim could divert resources away from the development of a reliable PPS, and toward the implementation and maintenance of an unwieldy and unreliable interim system.

Conclusion

There is widespread agreement that HHA expenditures are growing rapidly, that continued growth of this magnitude is unsustainable, and that legislative efforts are needed to slow down this growth. I have laid out for you today our vision for the future of the home health benefit and its payment system. It is my hope that we can work together to develop payment policies that provide the right incentives—incentives to provide quality care, promote access to care, and inhibit fraud and abuse. Thank you for the opportunity to testify today.

Characteristics of Medicare Home Health Users



Source: HCFA, 1994 Medicare Current Beneficiary Survey

REFORMING MEDICARE'S HOME HEALTH BENEFIT

Legislative Proposals from the President's FY 1998 Budget

- **Prospective Payment System** -- implement a PPS for HHAs in October 1999, with valid and reliable case mix adjustment system
- **Interim Payment System** -- effective until October 1999, achieve necessary expenditure control by reducing the HHA cost limit and introducing an annual "per beneficiary" cap
- **Payment at Location of Service** -- base payments on the location where the home care is furnished, not where the HHA office is located
- **Eliminate Periodic Interim Payments** -- effective at the introduction of PPS, eliminate unnecessary bi-weekly estimated payments
- **Clarify the "Homebound" Definition** -- bring clarity to the currently vague definition (by adding several calendar benchmarks) to emphasize that the benefit is available only to those who are truly unable to leave the home
- **Give the HHS Secretary Authority to Deny Payments Based on Normative Service Standards** -- allows us to work with the industry to establish normative visit standards for specific clinical conditions or situations
- **Restore Post-Hospital Home Health Benefit Under Part A and Transfer Other Home Health Service to Part B** -- restores the HI Trust Fund to its intended purpose and extends its solvency into 2007

Mr. BILIRAKIS. Thank you, Dr. Vladeck.

Has HCFA been made aware of a Moon Communications by Unitron System?

Mr. VLADECK. I'm sorry, I didn't hear the first part of that question.

Mr. BILIRAKIS. Moon—have you been made aware of a particular system designed by—I suppose all of the principals are in Florida; I'm not really sure about that, but, anyhow, it's basically a setup where they've set up a center in one of the local hospitals and they sort of have a monitoring type of a process to be able to actually monitor what is taking place in terms of the time. Obviously, they can't monitor all the details of the home health care. Are you aware of that system?

Mr. VLADECK. I'm not aware, Mr. Chairman, of that particular system, but we have received a number of proposals and talked to a number of individuals who are developing automated systems for establishing the actual presence of a home care worker——

Mr. BILIRAKIS. Yes.

Mr. VLADECK. [continuing] in a client's home, and we are—there are a number of such systems currently being developed and tested, and we are reviewing these systems.

Mr. BILIRAKIS. As I understand it, the home health care agencies are very interested in this sort of a system, too, because they're being taken advantage of by many of the people who supposedly are charging for home health care when they're not even there; is that correct?

Mr. VLADECK. Well, a number of the agencies have been very interested in these systems, and some agencies have installed these systems. I think it's reflective of the generic problem that is very difficult to supervise and monitor the performance of a worker in patients' homes in such a decentralized basis. And one of the things, which we try to address in our conditions of participation, are the patterns of supervision and recordkeeping that are necessary, so that the agency can be sure that people are receiving the services——

Mr. BILIRAKIS. Yes.

Mr. VLADECK. [continuing] which clients need and for which the agencies are being paid.

Mr. BILIRAKIS. Doctor, on page 2 of your written testimony, you refer to the intensity growth and the growth for the average home health beneficiary. It used to be 22 visits in 1980 on average and 33 visits 10 years later, and it's now 76 visits per user. Is that attributable mostly to fraud and that sort of thing? Why have we had a better than triple the average number of visits?

Mr. VLADECK. Well, I think there are several things going on all at once, Mr. Chairman, and I must tell you that, again, the information we can report to you is on the basis of limited survey data and particular studies. We will not, until we begin collecting this new uniform data, have the kind of data we really need to more adequately characterize this, but I think there are several things going on.

One is the average home care patient today is sicker than the average home care patient 15 years ago. Clearly, they've been discharged from the hospitals more quickly for a given diagnosis than

they were in the past. But, second, we are providing a lot more of what might be described as chronic community-based maintenance services to Medicare home care patients than was the case before the late eighties. We have, for example——

Mr. BILIRAKIS. Necessary, unnecessary——

Mr. VLADECK. Well, again, these are necessary services. Whether these are the services contemplated in the original statutory definitions of skilled, intermittent, and homebound as the criteria for receipt of services, I believe is an arguable proposition. But, again, there's no question that beneficiaries need these services. Whether these are the services that the Medicare benefit is designed to pay for, or meant to pay for, I believe is a very good question, and one of the things that we're going to have to try to clarify through the legislative process this year.

Mr. BILIRAKIS. Well, going again further to your testimony, you refer to 1994, the average number of visits per beneficiary is 126 in Louisiana and 76 in Arkansas and Florida, 97 in Texas, et cetera, et cetera, but Louisiana having almost double the next highest. And then you refer to the expenditures, too. The national average program payments per home health user was $4,000-plus and it was $6,700 in Louisiana, et cetera. Why? Why would that be? Mr. Tauzin is not here, so I feel free.

Mr. VLADECK. We don't fully know, Mr. Chairman, and I must say that the Prospective Payment Assessment Commission has done some wonderful research, looking at variations of use of all sorts of Medicare benefits. Dr. Young is here and may want to say some additional things about it.

Louisiana is a very high utilization State for almost every category of Medicare benefits. But the one other observation I can share is there appears to be some loose correlation between the availability of other publicly financed, community-based, long-term care services and the use rates for Medicare home care. That is to say, the three States that we identify here as relatively low—or the two States that are relatively low in utilization, New York and Oregon, probably have the most extensive systems of publicly financed non-Medicare home and community-based services for the frail elderly in the country. The States with high utilization tend to be States with very limited Medicaid programs and very limited title 20 or title 3 in-home programs as well. I believe there is some tradeoff between what is paid for from other kinds of service mechanisms and what is paid for in the Medicare home care benefit, which, again, speaks to the fuzziness of the definition of who should be receiving the benefits.

Mr. BILIRAKIS. That's very interesting.

Mr. Brown?

Mr. BROWN. Thank you, Mr. Chairman.

Dr. Vladeck, the reductions in payments to providers for certain benefits have often in the past resulted in physicians changing their practice patterns. This change sometimes has led to a loss of access to certain kinds of care for beneficiaries. The administration's interim proposal is expected to, my understanding is, realize scorable savings immediately upon implementation. Do you expect this change in payment to have any adverse effect on the ability of homebound individuals to receive care, No. 1? And, No. 2, per-

haps more problematically, is it possible in rural areas served by only a few, or in some cases perhaps only one, home health agency that these reductions would result in a loss of providers and a loss of access to care for beneficiaries?

Mr. VLADECK. It's always very difficult to predict exactly what will happen with a payment change of this sort, but I think it is fair to say that, judging by the repetitivity with which new agencies are seeking to enter the Medicare program, what we know about the financial performance of these agencies where either there is a publicly traded stock, so there's SEC-type information available, or where because of program integrity considerations, we've become more knowledgeable than we would have liked about their financial structure. There is considerable room in this system for reductions in revenue for volume while still permitting an abundant supply of economically healthy providers.

Mr. BROWN. And even in rural areas where you don't see too many cases anymore of only one or two providers? Is there enough incentive for new providers to enter the market?

Mr. VLADECK. We've had enormous growth in the number of Medicare-certified agencies throughout the country, including relatively rural communities. We have a number of other agencies that have been based in more metropolitan areas that have been expanding services into rural communities quite aggressively in recent years.

Mr. BROWN. I would imagine in response to discussions, statements, and questions today, about the incredibly accelerated use of home health care, some witnesses later today, I believe, will advocate beneficiary copayments as a way to give beneficiaries a stake both in home health billings and to further ensure that unnecessary services are not provided. The first chart you had up there showed that some 40 percent of home health recipients have incomes under $10,000. That being the case, talk to us, if you would, about what we should do in terms of co-pay.

Mr. VLADECK. Well, let me just say two things. The first is that copayments for Medicare home care would have a disproportionate effect on low-income and fixed-income beneficiaries. Although we don't have any literature that I'm familiar with on home health, general literature on copayments indicates that for low-income people, copayments discourage desirable or needed utilization just as much as copayments discourage unneeded utilization.

Second, we also have a real concern with the federalism aspects of this, in the sense that a significant proportion of beneficiaries will also be Medicaid-eligible, and, therefore, imposition of a copayment would involve a shift of part of the cost to the States, whether that's technically an unfunded mandate or not.

Mr. BROWN. Since Medicaid can pay or co-pay for nursing home service, would it kick-in here?

Mr. VLADECK. Well, Medicaid pays copayments for all low-income dual-eligibles, Medicare/Medicaid beneficiaries, and we believe perhaps 20 to 25 percent of Medicare home health visits are being provided to dual-eligible beneficiaries. So something on the order of 20 or 25 percent of any co-insurance would be borne by the Medicaid program. Now, again, 57 percent of that comes back as a Federal

Medicaid expenditure, but there would be some cost-shift to the States from that.

Mr. BROWN. Should we consider, Dr. Vladeck, any kind of means test on co-pay for home health care?

Mr. VLADECK. Well, if you do any kinds of means test on a service-specific basis other than that which, in effect, the Medicaid eligibility process or the QMB/SLMB special low-income protections provide, you get into a very formidable administrative task. We're not even doing such a wonderful job of identifying all the QMBs. So we'd be nervous about the administrative implications of a service-specific income-related copayment.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Brown. Dr. Coburn?

Mr. COBURN. Thank you.

Dr. Vladeck, can you account for the increased number of visits per beneficiary on the basis of either more extensive need for care, greater degree of illness, earlier discharge from hospitals? Why have we seen this tremendous increase in the number of visits?

Mr. VLADECK. Well, as you know, Dr. Coburn, in 1988 or 1989, we entered into a consent decree with the district court in the District of Columbia that essentially changed the way in which we defined appropriate claims for Medicare home care, and this decree changed the way in which we review the claims. And I honestly believe that what happened is that there was a significant reservoir of need in communities of beneficiaries who were at home who had significant impairments, both medical and functional impairments, who needed or could benefit from help in response to those impairments, who before 1989 were not defined or treated as eligible for the Medicare benefits as they were interpreted before then. Therefore, these individuals became eligible under what was, in effect, a reinterpretation of the benefits.

The primary thing that happened, in my view—and, again, our data is such that some of this is necessarily speculative—is that, in effect, we broadened the definition of the benefit to bring into coverage a broader pool of individuals who were already out there and in need of services, some of which they were receiving in other ways and some of which they were not receiving.

Mr. COBURN. So, in effect, you're saying sicker folks are now getting——

Mr. VLADECK. No, I would say different individuals.

Mr. COBURN. But how do you account for the number, increased number, of visits per patient per year?

Mr. VLADECK. Well, I believe that we are moving away from the acute visits. For example, one of the other pieces of data that we do have is that the proportion of all visits being provided by aides has increased very substantially as well. Much of the growth in very high-visit cases is on the less skilled side of the spectrum. I believe these are individuals who are suffering from chronic illnesses, who have chronic incapacities of one sort or another, who need assistance with activities of daily living and some limited amount of intermittent skilled service. It's a different kind of patient than the post-acute recuperative or convalescent patient more typical in the program in earlier years.

Mr. COBURN. You referred to the title 3 and title 20 program.

Mr. VLADECK. Yes.

Mr. COBURN. Is that the former Medicaid provider programs that used to be in the State?

Mr. VLADECK. Title 20 was actually a social service block grant that paid for some home care services, and in Oregon and a number of other States these programs helped finance—California as well, I think—helped finance community-based, long-term care services.

Mr. COBURN. Let me ask you a question. One of the things that I think is important as we look at this is there's no questions there's services that are needed; there's no question, you just testified that, the number of the home health care agencies and applications and their aggressiveness in terms of marketing their product has increased. Is there a way for us to do it more efficiently?

In Oklahoma—and I think my data is correct—for an aide to go by and to help bathe someone, I think the bill to the Federal Government is around $60, and that's for maybe an hour or hour-and-a-half's work for that individual. At least that's what occurred. That's what my patients are telling me they're seeing.

Mr. VLADECK. Yes.

Mr. COBURN. Is there a way for us to do that more efficiently? And the reason I ask that, under the former provider program in Oklahoma that was caring for the same people, it was costing about $12.

Mr. VLADECK. I think the short answer is yes. I think there are two components to the solution. One is you do need some way, as we do in Medicaid home and community-based waiver programs, to pool funds and to have a single provider agency able to make tradeoffs between the kinds of services people need. Second, you need some defensible, objective criteria to determine who is getting the benefit and who isn't. If you combine great flexibility in service delivery with an open-ended intake in a sense, then you can control your cost per client, but you can't control your overall expenditures.

Mr. COBURN. I just wanted to relate one short story before my time's up, and it's a doctor by the name of Snyder from Tallakwois, Oklahoma who wrote me a letter, and he was brought up before the ethics board in the State of Oklahoma for denying to order home health care on a patient that had diabetes. The patient's wife was a nurse, trained to measure sugars and give injections. The family just did not want to do that. This patient last year you all paid for about $55,000 worth of care for his diabetes when, in fact, somebody in the home is capable of caring for him. Is there any plans by the administration to look at personal responsibility in terms of what is—rather than spending money that will duplicate an effort that's already in the home?

Mr. VLADECK. Well, one of the things we'll be learning through OASIS and other data collections is what kind of supports, nonprofessional supports, are available to the patient in the home or in the residential setting. And one of the things we have done most poorly in all our long-term care programs is to figure out how to get professionals and family members working together better.

We just had a staff meeting in the agency on Friday to discuss this issue. We know we need to do better, but we have a ways to go. But part of the first step is characterizing the problem by find-

ing out how many such instances there are when there's a family member who's capable of providing a relatively broader range of services.

Mr. COBURN. Fine. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Doctor. Ms. Eshoo?

Ms. ESHOO. Thank you, Mr. Chairman.

Good morning, Dr. Vladeck.

Mr. VLADECK. Good morning.

Ms. ESHOO. Could you briefly and succinctly explain why you went to the recommendation that's before us, the administration, to a prospective payment and what other options you looked at? Why do you believe this is the best answer? It seems just a little reminiscent of the debate that's going on right now about the CPI and the basket of goods and how it's measured, and whether that's current or isn't, and how you come up with it. From what you've said since I came into the hearing room, it seems fuzzy in terms of what you're measuring. I'm not so sure how clear that is, and it leads me to the question of, How did you come up with this as being the recommendation contained in the President's budget?

Mr. VLADECK. I think that's a very good and fair question. I would say that we have for at least a decade been putting limits on the amount we would pay per visit for home health services, and as we've been discussing, much of the growth in outlays for home health in Medicare has been driven by the increased number of visits per beneficiary being served. We don't yet have very good criteria to answer the critical question of: what's the right number of visits or what's the right range of visits? But we believe that if we can get enough information, we can design a prospective payment system which will, in effect, put an overall cap on expenditures per patient, based on the health care needs and the characteristics of that patient and some empirical information about the relationship between needs and the mix of services the patient requires. And that's the underlying logic of a prospective——

Ms. ESHOO. Do you have any other options? Did you examine anything else before arriving at this?

Mr. VLADECK. Well, again, we have been refining and modifying per-visit limits. We actually did a demonstration testing of prospective limits on per-visit payments to home care earlier in the decade that involved several dozen agencies around the country that volunteered to participate and collected a lot of information. We have looked at the issue of some kind of capitated or population-based payment for home care services as part of, say, a capitation rate to a Medicare HMO or a so-called bundled payment to the hospital from which the patient was discharged.

As far as we can tell—and we don't yet have a detailed prospective payment system to put in front of you, but it looks to us, given the complexities of this issue, like the least-worst approach to payment for services.

Ms. ESHOO. Well, it's a simple statement—home health care—or title, but there are many complexities. Either a DRG or you capitate certain services or you—and it changes from area to area. So I'm having trouble connecting the dots of exactly how this is going to work. It sounds very tidy when you say, you know, a prospective system, so that you can tighten the flow of dollars, and,

yet, I think in terms of what I learn from my constituents—and I don't know if in the examination of this whole issue if you've worked closely on the issue of fraud and abuse and also on the issue of what is reimbursable relative to Medicare when you're in a hospital setting and how expensive it is there, and how Medicare does not allow the same kinds of services to be reimbursed if, in fact, it's in a home health care setting. I think that that's an area, and I don't know how much review you've done of that, but it's a frustration of mine because, as constituents give me the absolute details—and we call it into an 800 number or write a letter to the agency—it might as well be shoved right under this table. I mean, it just doesn't go anywhere.

And I know that it seems anecdotal to the agency, but I can't help but think that a thorough review of that would help with the cost, bring more common sense to how we reimburse, and that it's far less costly in a home setting. So I don't know if you've meshed that or taken that into consideration in what you're here for today to testify. I'm having trouble figuring it out or hearing it from you, and I don't know if this has been taken into consideration or not.

Mr. VLADECK. I think the underlying question is really the relationship between the needs and characteristics of the patient and the services the patient needs, and what's the best——

Ms. ESHOO. That's always the case, though, but let me just add that that's exactly what's not taking into consideration under the present reimbursement system, where it costs "X" number of dollars to do whatever in a hospital, but Medicare won't reimburse it, but it can't be done in a home setting. So, again, my question is: in your review of all of this, are you examining a shift, so that there can be a savings from one part of the system placing it in the other? I don't know whether I'm being clear to you. I sure know what my constituents say to me, and I think other members have heard this as well.

Mr. VLADECK. Well, I can only say that one of the reasons we're spending so much money on home care in the Medicare program is because 17 years ago the Congress accepted the argument that expanding the Medicare home care benefit would——

Ms. ESHOO. I wasn't here 17 years ago.

Mr. VLADECK. No, but I——

Ms. ESHOO. I understand that. It makes sense that we are going to have more people in home settings because people are living longer, and insurance companies are throwing them out of the hospitals earlier. So if there's an area where there's going to be a growth, it's home health care. The issue is how we make best use of the dollars to take care of people in their homes. And my question to you is: out of the hospital side of Medicare and the re-examination of that, and the savings of dollars from that system, have you actually looked at that as you examined the home health care area?

Mr. BILIRAKIS. Brief answer, please, Doctor.

Mr. VLADECK. Yes, and we can talk about that more later on.

Ms. ESHOO. Okay.

Mr. VLADECK. Or Dr. Young can talk about it.

Mr. BILIRAKIS. And, of course, it's a very profound question, and that's the bottom line, I guess, of what we're trying to accomplish.

Mr. Whitfield?

Mr. WHITFIELD. Thank you, Mr. Chairman. I had to step out of the room, so I'm not sure what you covered, but if I ask a question that you've already covered, you can just say so.

Mr. VLADECK. I'll see if I can give the same answer or not.

Mr. WHITFIELD. All right. Well, you know, in the 104th Congress, of course, we had proposed a prospective payment system for home health in our Balanced Budget Act of 1995. Of course, the President vetoed that. And now you all are coming forth with your PPS, and I was wondering if you might explain what the primary differences are in the two.

Mr. VLADECK. I'd be happy to. I think, actually, the long-term goals and descriptions of the prospective payment system under the President's budget and those in what Congress enacted in 1995 are not very different. The critical difference is in the interim or transitional steps to get there.

As I understand it, being where we are now in 1997, we are talking about, if we were to enact again something like what the Congress enacted in 1995, a transitional system on a per-agency capped basis in 1998 and a separate transitional system on a per-beneficiary cap basis in 1999, both of which would use a measure of case mix variation or a case mix indicator, which we used in our earlier demonstration program and rejected because it didn't do a very good job of explaining differences in case mix. We propose a more gradual movement toward a prospective payment system, one that much more incrementally builds on our existing limits and places general caps on the agency level for the two intervening years before going to prospective payment in 1999.

So, again, I think the long-term objectives of the systems are relatively similar. I believe the issue is really how much you save in the transition, how complex the process is, and how willing you are to adopt as an interim measure of case mix, which doesn't work very well.

Mr. WHITFIELD. So primarily the only difference is just the interim or transitional steps?

Mr. VLADECK. I believe so, yes.

Mr. WHITFIELD. Now I know you all are developing several PPS models for not only home health, but other post-acute providers as well, and you've contracted with the Rand Corporation, Mathematical Research, and Apt Associates. I was wondering, Could you explain exactly what those companies are working on?

Mr. VLADECK. I honestly, Congressman, can't remember which contractor is necessarily doing which study for us, but we are doing several different things. One is that we are doing some research concerning particular home health agencies involving the relationship between the volume of services being provided, the cost of these services and the characteristics of their patients. We've been working to field test OASIS, or the patient assessment mechanisms, in a number of places. We've been working to do a demonstration of a per-episode or per-patient-based prospective payment system. We have the University of Colorado conducting research for us on trying to tie the characteristics of individual patients to measures of the appropriateness or quality of in-home services. All of these activities are going on, but I'd have to ask my

staff to indicate which of our researchers is conducting a particular project.

Mr. WHITFIELD. And when do you anticipate that they will complete their work?

Mr. VLADECK. Well, all this work is in process. I was told by our research demonstration staff that we would have all of the data we needed to design and test a prospective payment system in order to put such a system up in place in the year 2000, and I said, if the researchers tell us that, then we can do it in 1999. We now have revised a lot of our schedules, so that by late next year or early 1999, we should have sufficient data to simulate and to test in a variety of ways the payments.

Mr. WHITFIELD. Could you also give me the name of the court cases in the eighties that required the liberalization of——

Mr. VLADECK. The key case was—it was captioned Duggen v. Bowen, I believe.

Mr. WHITFIELD. Duggen v. Bowen?

Mr. VLADECK. Yes. I don't know if it was referred to, actually, in the testimony, but we can give you the full legal citation, if that would be helpful.

Mr. WHITFIELD. Okay. Is it in your testimony? It's in your testimony? Okay.

Thank you. I'll yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Ms. DeGette?

Ms. DEGETTE. Thank you, Mr. Chairman.

Doctor, I just have a couple of questions. I'm concerned—currently, under the current statutory definition, homebound is pretty loose, and as I understand it, what you're proposing is to redefine it. My concern is that there are many more people who are going to be eligible under a looser definition, and as the demographies of this country change, we're going to see an increase in the number of individuals who need daily medical assistance at the same time we're tightening up this definition.

I guess I'm wondering what options do you foresee will be available for the category of individuals that doesn't meet that tighter definition.

Mr. VLADECK. Well, I think if I may answer your question a little bit by perhaps broadening it, let me say—and perhaps I should have said it at the outset of my testimony—that if one looks at the entire bundle of changes which we are proposing for the Medicare home health care benefit, these changes do not comprise a full strategy for meeting the long-term care needs of our elderly and disabled population at the end of this decade or into the future. I think there are a number of missing pieces. If we're going to have the kind of service systems for the frail elderly in the community, and the frail non-elderly in the community as well, we need additional changes.

I think what has happened, particularly in some States, is in the absence of adequate supply of a broad range of services which individuals need in the community. The Medicare home care benefit, since the consent decree, has come to fill in this gap. Dr. Coburn was referring earlier to previous programs that exist in parts of Oklahoma, for example. I know in New York there were—in my home—there were a set of programs that have since been sup-

planted by Medicare home care, since the benefit was liberalized. But we can't afford, nor can we within the basic intent of the law, turn the Medicare home care benefit into a substitute for the kind of comprehensive, community-based, long-term care services which we're going to need in this country. Medicare has a role to play; the Older Americans Act has a role to play; and private resources have a role to play.

Unfortunately, with all the other things on our plate, we probably have not—we did attempt these issues to a limited extent in health care reform proposals in 1993 and 1994, and we haven't been back, and maybe we need to be. The short-term answer is that we don't think you can solve all these problems, nor should you, through the Medicare home health benefit. We will be leaving these questions unanswered by our proposed changes to the Medicare benefit.

Ms. DEGETTE. I guess that's an answer, but what efforts are being made—and this is probably a little more global than the subject of this particular hearing, but I think what we end up doing is shoehorning a lot of issues in, so that we can provide these folks the services they need. What kind of efforts are being made to develop some kind of a comprehensive program?

Mr. VLADECK. Well, we are both expanding our existing demonstration activities for community-based, long-term care programs. We are in extensive discussions with a number of States, including, I might say, Colorado, regarding the design of new experiments in community-based, long-term care delivery that would involve both Medicare and Medicaid payments. What we need, I believe, is a next generation of 10 or 12 tests at the statewide level or the communitywide level of new, comprehensive systems of care delivery, so we can learn more about how to implement it. We can then develop the benefit structure in legislation to make these things more widely available.

Ms. DEGETTE. And I've been hearing about your Colorado pilot project from my home folks. I'm looking forward to sitting down and talking about it.

Mr. VLADECK. They're good folks there.

Ms. DEGETTE. Thank you. I yield back.

Mr. BILIRAKIS. I thank the gentlelady. Dr. Ganske?

Mr. GANSKE. Thanks, Mr. Chairman.

Dr. Vladeck, as I mentioned in my opening statement, I am concerned about switching around some accounts, but I have a feeling that is above your and my pay grade, and so I'm not going to go into that in any great detail.

I want to follow up on a line of questioning that Mr. Brown started. Now, Dr. Vladeck, in the current Medicare system there are copayments and there are deductibles; is that not correct?

Mr. VLADECK. That is correct.

Mr. GANSKE. In your opinion, do those copayments and deductibles provide a function in terms of decreasing overutilization?

Mr. VLADECK. Well, they decrease utilization, including decreasing some desirable utilization for lower-income beneficiaries or beneficiaries who don't have supplemental insurance.

Mr. GANSKE. But you wouldn't recommend doing away with the copayments in the current system, would you?

Mr. VLADECK. Well, on some targeted services, in fact, in the budget bill—for example, for mammography, where we know that the copayment discourages low-income women from getting mammography we proposed eliminating the copayment. We have also proposed eliminating copayments for the hepatitis B vaccine.

Mr. GANSKE. See, some of us think that that would be the function for medical savings accounts, but I won't go into that. But I think it's clear that the copayments serve the function of ensuring that it is an important issue before a patient goes to their doctor for just a sniffle, right?

Mr. VLADECK. Well, if I may, it's clear that copayments discourage utilization. They have a much more significant effect on discouraging utilization for low-income people than for more affluent people, and among low-income people, they discouraged "desirable utilization" as much as they discourage "undesirable."

Mr. GANSKE. In the current system, though, where we do have copayments, I mean, we also have title 19.

Mr. VLADECK. That's correct.

Mr. GANSKE. So that people who are poor can be taken care of; is that not correct?

Mr. VLADECK. That's correct.

Mr. GANSKE. Okay. So there is a mechanism whereby we are looking at the ability of somebody to pay a copayment. My point is this: I remember about a year ago a physical therapist coming to me and talking about home health care, and she said, "You know, Congressman, I'll get an assignment to go out and give a week's worth of physical therapy to somebody who's had an operation or something, and it may be an elderly lady who lives by herself out in the country, and after I've done my thing for a week and she's better, I'll tell her, 'well, I think this is it. It's been nice taking care of you, and you're getting along fine.' And this elderly patient may then phone her family physician and say, 'You know, I think I need another week of home therapy.'" And it becomes very difficult for that family physician to deny that.

What may be going on is that, in fact, this elderly patient may have enjoyed that home visit and having somebody to talk to every bit as much as there being any need for the actual physical therapy. But as long as it's "free," then there's no disincentive to overuse.

We did look at a prospective payment system in our bill last time. I am concerned, though, now, as I was then, about the type of bureaucratic structure that you need to implement that type of plan. There surely is some fraud and abuse in the home health care industry. I'm sure you'll agree with that. So that will have to be looked at regardless of what kind of system that you have.

If we can, in the other parts of Medicare, use a copayment that takes into consideration poor, who we don't want to underutilize needed services, why cannot we not do the same thing for the home health care system? Or, put it on the flip side, and take up Mr. Brown's question. Yes, there may be people that simply don't have the resources, but there certainly are consumers that do. Why do

they not have some type of responsible copayment for the services that they're utilizing?

Mr. VLADECK. Well, permit me to take the reverse side, as you suggested, and look at the 70 percent of beneficiaries who have a supplemental policy which pays some of their co-insurance. The underlying problem is that neither that physical therapist nor that physician is operating within a framework in which the professional norms and the professional expectations about the relationship between the patient's condition and the appropriate level of services has been well enough specified for either the provider of services or the payer to make a defensible judgment. In that case, to basically turn the decision about the appropriate level of utilization into a willingness to pay out-of-pocket decision seems to me not to get us where we want to go in terms of the 80 percent of the cost for which Medicare would still be paying.

Mr. GANSKE. But, Dr. Vladeck, that's the way it is for the majority of people in this country. Even the managed care industry is instituting copayments and deductibles on their plans because they realize that a basic fact of human nature is that when something is free, people tend to overconsume it.

Mr. VLADECK. Well, all I would say, Dr. Ganske, is that even for those Medicare beneficiaries for whom, because there's an employer-paid supplemental policy or because there is Medicaid co-insurance, the problems of potential utilization don't go away by the creation of co-insurance in the Medicare program. We have problems of significant overutilization of some physician services on which we've always had a copayment. So that's not—one could argue the desirability of a copayment back and forth, but, as evidence that it would adequately control tendencies toward overutilization, I think our experience in both Medicare and private insurance suggests that by itself it doesn't solve the utilization problems, particularly when the professional consensus about the appropriate level of service is as weak as it is for much of home care.

Mr. GANSKE. Well, I would agree with you that there's need—that, by and of itself, it would not be sufficient, and that's why you need to have appropriate oversight against fraud and abuse.

There's a whole other issue, Mr. Chairman, to deal with another type of solution which we talked about before in terms of competitive bidding, which a number of members on the other side of the aisle had indicated an interest in, but my time has run out. I thank you, Dr. Vladeck.

Mr. BILIRAKIS. Thank you. Mr. Burr?

Mr. BURR. Thank you, Mr. Chairman.

Dr. Vladeck, let me just read part of your testimony real quick. It's page 2.

"While they were often"—this is under "Reasons... Utilization Growth"—"While they were often undertaken with the belief that they would reduce total costs by shifting resource use from more expensive (hospital) to less expensive (post-acute care) settings, for the most part, these policy changes were not systematic attempts to reform Medicare. Rather, they occurred piecemeal throughout the years to achieve specific objectives."

Given that I don't believe that the administration is, in fact, reforming Medicare, what is the specific objective that you're after now?

Mr. VLADECK. Well, I don't want to get into a semantic argument, Mr. Burr, but I would say that, if you take all of the changes in the Medicare program which we are proposing in the President's budget bill, it looks pretty systematic to me.

Mr. BURR. Well, I think that certainly we'll have an opportunity to look at it piece by piece, but there is every reason to question some of the things that you've got in this bill.

Let me ask—under the interim health payment system, you propose that you take the least of three options about what we pay. Now let me ask—taking the least of three options, is HCFA worried at all about the quality of care or interruption of care?

Mr. VLADECK. We're very worried about the quality of care, but our experience with home care to date suggests almost total absence of any systematic relationship between what we're paying and the quality we're getting. We don't have great anxiety that reductions in payment level will have an adverse effect on quality.

Mr. BURR. Has HCFA compared the experience in the non-Medical population, say 63 to 65, where it's privately insured and they access home health care, to in fact the Medicare population that's covered? Have you looked at per-visits? Have you looked at any correlations between the two to see the experience?

Mr. VLADECK. We haven't looked in great detail in recent years, in part because the prevalence or the volume of home health being provided to non-Medicare populations is—unless there are special beneficiaries with special disease categories—so much lower than it is in Medicare that it's hard to get the right kind of base to look.

Mr. BURR. Well, it is not hard to get, but let me ask—I mean, weren't we the ones that encouraged the growth of SNFs and of home health care, in the fact that the payment plan that hospitals adopted there was incentive to move out patients earlier?

Mr. VLADECK. What we are trying to convey in the testimony is that by moving services from the hospital to SNFs or to home health agencies, there would be a saving of money.

Mr. BURR. Under their payment plan, though, can, in fact, hospitals keep any savings?

Mr. VLADECK. Well, in the short-term, in any given year, hospitals keep the savings from reduction——

Mr. BURR. Is there the same type of incentive built into the proposed payment plan for home health to show the same type of encouragement to expedite the process? Is there a savings under the payment plan, the interim payment plan or the——

Mr. VLADECK. Under our proposed interim payment plan, the incentive to save money by substantially reducing the volume of services is very limited. But that's why we have to be careful about designing a true prospective payment system, so that we get these incentives right.

Mr. BURR. Let me ask you, in your legislation, is it true that you propose in the year September 1999, after we've gone through this interim payment period, before you adopt the permanent pay, that in fact the cap that's established you will cut by 15 percent?

Mr. VLADECK. That's correct.

Mr. BURR. So how did we come up with that?

Mr. VLADECK. We came up with an estimate of our sense of what we were now paying and an estimate of what we thought could be taken out of the system——

Mr. BURR. So we've come up with an interim payment plan that could very possibly be the permanent payment plan, and we have already built in in the fourth year—or I think it's the third year—a 15 percent reduction automatically. Why don't you take the 15 percent reduction now?

Mr. VLADECK. Well, because, again, the idea is, without a good measure yet of appropriateness of services on a patient-specific basis, you could be taking the 15 percent out of the wrong place, whereas if you have a set of empirically grounded measures of relationships between patient characteristics and service needs, you can identify more appropriately places to cut that will have less of an adverse effect on patients.

Mr. BURR. Isn't it really to make the budget balance?

Mr. VLADECK. It didn't—it didn't hurt in terms of making the budget balance.

Mr. BURR. Good answer.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. BURR. Let me ask you one, with the chairman's indulgence for one last question——

Mr. BILIRAKIS. Quick.

Mr. BURR. Mr. Vladeck, you also suggest that we need to get involved with the administration of these companies by at least suggesting that they be required to have permanent employees versus contract employees. Is that, in fact, a true interpretation?

Mr. VLADECK. We believe that there is a qualitative difference between agencies that are little more than personnel contractors and agencies that really provide home services directly, yes, sir.

Mr. BURR. As somebody who's fresh out of the business world, let me suggest to you that what we're doing is suggesting we're going to pay less for a service; yet, we're going to mandate to them a requirement for higher cost on their part, and if we want a partnership to find the most efficient, most cost-effective, quality-of-care delivery system, that in fact that will be a knot in the whole chain.

I yield back, Mr. Chairman.

Mr. BILIRAKIS. There's nothing to yield.

Dr. Norwood?

Mr. NORWOOD. Mr. Vladeck, thank you for being here, and I want to compliment you and your staff on having the testimony to us well in advance of the hearing. I think if we can complain about it when you don't, we should also thank you when you do.

Mr. VLADECK. I appreciate that.

Mr. NORWOOD. Mr. Bilirakis, thanks for having this hearing. I won't need any more time than my friend, Mr. Burr, to ask my questions.

Mr. Vladeck, some quick questions, short answers, please, and then I have a long answer. How many employees at HCFA?

Mr. VLADECK. About 4,000, sir.

Mr. NORWOOD. How much money do you handle in 1 year?

Mr. VLADECK. Total estimated for this year, about $300 billion.

Mr. NORWOOD. How much waste, fraud, and abuse do you expect that you had in home health care last year?

Mr. VLADECK. I will defer an answer to the Inspector General, but I would say it's a number with a "B," not an "M." I think it's in the hundreds of millions or as much as a billion or more.

Mr. NORWOOD. In your written testimony, you state that the administration's prospective payment system will not take effect until October 1999. Given the problems that we obviously have in the home health care system, why 2½ more years to develop this system?

Mr. VLADECK. Again, I believe if you do prospective payment system wrong, you can put patients at considerable jeopardy, and we don't have confidence of the ability to adjust payments to patient characteristics, given what we now know. We need to develop the technology that will permit us to do that.

Mr. NORWOOD. So it will take 2½ years to do that?

Mr. VLADECK. Again, my staff said it would take 4; we're committed to doing it in 2½.

Mr. NORWOOD. How difficult is this task?

Mr. VLADECK. Well, it involves the collection of a substantial amount of information, which until now has not been routinely connected—collected or connected.

Mr. NORWOOD. How hard is this PPS to administer? I mean, I'm trying to get a handle on this way of solving the problem, just to how much work are we giving 4,000 employees.

Mr. VLADECK. Well, most of the work would, presumably, be done by our contractors. Administering the system, once it's up and running, is not the hard part. It's developing and testing it and making sure it works is the hard part. In order to do that, we need to know a lot more about the characteristics of our home care beneficiaries and the services they're receiving than we now do.

Mr. NORWOOD. So when it's up, the administrative task you don't think is that difficult?

Mr. VLADECK. Well, I think we put in prospective payment for hospitals in 1983 without any significant increase in the administrative structure of the Medicare program at that time.

Mr. NORWOOD. If you have 4,000 employees, how many contractors do you have?

Mr. VLADECK. We now have about 70 contractors for Medicare payment, for claims payment and bill processing, and so forth.

Mr. NORWOOD. So you have 4,070 people working for HCFA?

Mr. VLADECK. No, sir, we have about—the contractors collectively employ, I believe, about 25,000 people.

Mr. NORWOOD. That gets me a little better. It seems to me you have a very difficult task. Do you think there's any such thing as a system in Washington that is just too difficult to manage because it's too complex?

Mr. VLADECK. I'm sure there are.

Mr. NORWOOD. I want to repeat some of the questions that have been asked all up and down the line on both sides and try to say it in a different way. Do you believe in human nature?

Mr. VLADECK. And it's perfectability, sir.

Mr. NORWOOD. Do you believe American people will spend all they can get their hands on when it's somebody else's money?

Mr. VLADECK. No, sir, I don't think our experience in the Medicare program shows——

Mr. NORWOOD. I didn't ask you—I'm asking about human nature. Is the inclination of the American people to spend all they can get when it's somebody else's money?

Mr. VLADECK. That's not my experience.

Mr. NORWOOD. Okay. You and I have been traveling in different circles.

How about, Do you happen to believe that people will use a service or a product to a greater degree when it's free?

Mr. VLADECK. Absolutely.

Mr. NORWOOD. You do believe that?

Mr. VLADECK. Yes, sir.

Mr. NORWOOD. Why is it that we just will not consider human nature in trying to solve these problems rather than spending 2½ years to try to solve the problem? And what I mean by that, basically, is: why not means test? I don't want the answers too administratively difficult because the answer there needs study to determine how much money difference are you talking about in administration versus means testing. That solves the problem.

Mr. VLADECK. I don't know what you mean by means test in this instance, sir.

Mr. NORWOOD. In my view, it would be from the people who have the least amount of money to those who have most, knowing we need and want to protect those who have least. But a copayment, for example, of a quarter would affect some people. If you want to stop overutilization in home care, go to human nature.

Mr. VLADECK. Well, again, given our experience with co-insurance and the rest of the Medicare program, we have benefits with lots of co-insurance and lots of overutilization. It makes a difference, but it will not solve the utilization problem by itself.

Mr. NORWOOD. No, but it will go a long way toward helping. It will certainly get at part of that $1 billion worth of waste, fraud, and abuse that the taxpayers are going to pay next year.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. NORWOOD. Thank you, sir.

Mr. BILIRAKIS. Well, without objection, take another 30 seconds.

Mr. NORWOOD. This should be a very quick answer.

Mr. BILIRAKIS. It should be, yes.

Mr. NORWOOD. No, the question's a little long; the answer is short.

How many years will this shift in home health care services from Part A to Part B add to the life of Medicare Part A trust fund?

Mr. VLADECK. In conjunction with the other proposals in the President's budget, taken together, there is an estimate that the expected life of the trust fund will be extended to the year 2007 or about 6 years longer than under current law.

Mr. NORWOOD. We are all in agreement here that the way we're trying to solve this problem is go to a fund that comes from a fund that we presently borrow $500 million a day every day on; are we all in agreement on that?

Mr. VLADECK. I'm not——

Mr. NORWOOD. The Treasury borrows $500 million a day. Part B is paid for generally out of the Treasury. That's how we're solving a problem—going to the Treasury that borrows money.

Mr. VLADECK. No, sir, we are doing this as part of a balanced budget proposal that eliminates deficit financing of the Federal budget by the year 2002.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Deal?

Mr. NORWOOD. Ask him if he believes in human nature.

Mr. DEAL. Thank you for being here. Let me ask you just a few questions.

First of all, I have noticed that in my area there has been an increase in acquisitions of home health agencies by hospitals, as I have noticed an acquisition by them of nursing homes, et cetera. Is this a trend that is prevalent throughout the country?

Mr. VLADECK. Yes, sir.

Mr. DEAL. How do you view that? Is that good, bad, or indifferent?

Mr. VLADECK. We're very concerned about it in two regards. First—and we have some administrative steps in process to remedy this—we are concerned that patients being discharged from hospitals which own home care agencies or other post-acute services may not be getting as broad a choice as to where they receive post-acute services as they should be.

Second, again, the Prospective Payment Commission has done an excellent job of documenting how, by earlier discharge of the patients from the acute hospital to a hospital owned or controlled home care agency or skilled nursing facility, or other facility, hospitals are, in a sense, collecting twice for a service for which we ought to be paying once. And we have some proposals, again, in the budget proposal to address that problem.

Mr. DEAL. What specifically?

Mr. VLADECK. Well, we believe that when a hospital discharges a patient to another hospital-controlled facility, we shouldn't pay the hospital a full inpatient price plus a full post-acute price; that, in fact, we should pay the inpatient acute service as though it were being transferred to another hospital, which is a reduced price for that service.

Mr. DEAL. With regard to the growth of propriety home health agencies—and as I noticed, that's something like 21 additional visits per year of a propriety versus a not-for-profit home health agency—what is specifically being done to try to account for that variance?

Mr. VLADECK. Well, again, it has to be looked at in the context of the overall effort to try to get substantially better information on who is being served by what agencies and what categories of patients are receiving what group of services. I think it's not clear that, because the proprietary agencies are providing more services, there's something wrong with that. It may be that the not-for-profit agencies were traditionally providing too few services. It gets to the question that we need to know a lot more about the link between the number of visits being provided per patient and the characteristics of that patient. That's what our new data collection and information strategies are all about.

Mr. DEAL. I spoke to a medical group this week in my State, and afterwards a doctor came up to me whose primary complaint was the fact that he was being handed pre-prepared plans of care prepared by the home health agency that he was asked to simply sign off on. For him to alter that, he had to complete a great amount of paperwork. I notice in your prepared remarks that you are looking into that, and that you're encouraging physicians to have a greater role in the home health care plan.

How are you giving those incentives?

Mr. VLADECK. I must confess considerable disappointment. Two years ago we raised the fee we pay physicians for management of home care cases after some extensive discussions with physician groups, in the hope that that would cause them to take a more active and involved effort in overseeing the actual care that patients for whom they were prescribing home care received. In fact, we have paid the additional dollars to the physicians without any measurable improvement in the extent to which they've actually been involved in managing these cases. So we are going to try a different strategy next time in terms of patient education, in terms of physician education, in terms of working with the medical community on some of these issues.

Mr. DEAL. I notice that there has been, apparently all across the country, a proliferation of home health agencies that are certified. As one who has very mixed emotions about even asking a question about certificate of need, because our State has been going through the throes of being in it and working its way out of it, how do you propose to perhaps slow down this proliferation? I know you perhaps can do it through the certification process. Is there any other logical way? And does the proliferation itself lead to what I consider the most startling statement in your prepared statement, and that is that 25 percent of all payments may be inappropriate in this industry?

Mr. VLADECK. It certainly makes it harder for the individual agency to do high-quality business when it's very small or very new, and it's much harder for anyone to monitor the quality or performance of service. I believe what we need to do is raise the entry requirements for home health agencies and we need to do this in the Medicare program more generally, and this committee in its work on the program integrity parts of Medicare last year gave us a little of a headstart. We need to raise the bar of entry, of qualifications, for home care agencies and other firms that seek to do business with Medicare. We have to have some greater assurance of fraud and that these agencies have the organizational and administrative capability to do a high quality job. I think if we do that, over time there will be at a minimum a significant deceleration in the rate of new entries to the program, and in fact, some consolidation over time.

Mr. Burr made reference earlier to our intention to require that agencies provide a higher share of services directly rather than by contracting with other providers of service. And, we think by itself that it should slow down the rate of entry and produce stronger, better qualified agencies and some further consolidation.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentlemen's time has expired. Mr. Bilbray.

Mr. BILBRAY. Thank you, Mr. Chairman. Just a follow-up comment on Mr. Norwood's issue about the use of free products: I think the proof's in the pudding, when one of the most aggressive marketing strategies in this country is to give free samples to get consumers to do something they normally wouldn't do if they had to pay at all. In fact, there's one industry that we've been really on them about not giving free samples because we recognize how much of an enticement that is to the consumer to go ahead and do something or try something if there is no related cost.

But getting back specifically on this issue—the HMOs and other managed care organizations offer home care services, and yet they've been able to keep the costs of these services under control. Would you like to comment on that observation?

Mr. VLADECK. Yes, sir. We have only one strong study with which we're familiar in the literature of this issue. It was one performed by the Health Services Research Center at the University of Colorado by some very capable folks, but their data seem to suggest that to the extent you could measure what an appropriate level of home care utilization is for Medicare patients with certain characteristics, while there is an oversupply of home care in Medicare fee-for-service, there is a measurable, and frankly somewhat troubling, undersupply of home care services for HMO patients—at least for the HMOs they studied. That is to say, in their study, beneficiaries were being sent home with some post-hospitalization needs that ordinarily would be expected to require home care services and not getting those services. So, again it's one study, it's one point-in-time, it's a limited number of agencies, but the one good bit of data we have raises concern as to whether HMOs are providing an adequate amount of home care services.

Mr. BILBRAY. This is the Colorado study?

Mr. VLADECK. Yes, sir.

Mr. BILBRAY. Let me suggest that you try to find one in California because our indication suggests the opposite on that. But, they have been basically saying that there has been a restriction on how much home care is provided through the HMOs?

Mr. VLADECK. That's correct, and, again, that's with a pretty sophisticated effort to measure not only the level of service being provided, but to try to get a professional estimate of what the right level of service is.

Mr. BILIRAKIS. Okay, and would you agree that 25 percent overutilization is not the right level of service?

Mr. VLADECK. In the aggregate, absolutely not.

Mr. BILBRAY. Okay. I think we got that aspect down. Let me just say that the other issue really comes down to the fact that home health services is one of the fastest growing components of Medicare. I think both sides of the aisle will agree that the spending in this area appears to be out of control, and yet in this budget, the President proposes in 1998 that home health providers get considerably better treatment than did, let's say, the Medicare HMOs which loses $44 billion over the next 5 years and hospitals which will lose about $33 billion.

Considering the fact, at least in California, we've had some considerable good, through many medical managed care programs and

organizations, aren't we punishing good behavior and rewarding the negative?

Mr. VLADECK. No, sir, I think that's just wrong. I think, as a percent of total payments, we are proposing larger reductions in home care than any other category in Medicare savings, and certainly much larger in proportion than our cuts in either hospitals or HMOs.

Mr. BILIRAKIS. Are you proposing 25 percent reduction off the top?

Mr. VLADECK. No, sir.

Mr. BILIRAKIS. Well, don't we have some kind of indication that that's overutilization right now?

Mr. VLADECK. But, we don't know—the problem is, again, that while on average overutilization may be 25 percent too high, there's a lot of appropriate utilization, and just cutting all payments 25 percent doesn't solve the overutilization problem and may damage the appropriate services as much as eliminating the inappropriate services.

Mr. BILBRAY. Well, let me just say that there are some of us who have provided these services and it looks like that attitude is what's being applied to the managed care programs and the hospitals across the board. In fact, there is sort of a frustration when a generalization like that is being applied to everybody regardless of their individual efficiencies or deficiencies, and just what you said should be applied by the administration on the other side of it.

But, there seems to be inherently a bias that is being reflected in this budget that doesn't reflect the record of these three identities. There just seems to be a double standard that home health care providers or the whole strategy tends to be given a preference over the other two.

Mr. VLADECK. Well, again, sir, I think that our reductions in payments to home health agencies in the President's budget proposal are much more substantial than are the reductions in payments to either hospitals or HMOs.

Mr. BILBRAY. Okay, maybe we need to sit down and look at the same budget. Thank you.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Green?

Mr. GREEN. Thank you, Mr. Chairman, and I appreciate the opportunity again to have HCFA back before us. It seems like we might as well do this every week.

My first question is that during my first two terms in Congress I served on the Government Reform and Oversight Committee, and was on the subcommittee that considered—we had hearings on the Medicare system and Medicaid, and also the fraud and abuse and the difficult time in excluding fraudulent providers in the program. Once fraud and abuse is found in a home health care program, what does the administration plan to do with these fraudulent providers? Are we treating them just like we would a hospital or another health care provider? It seems like with this growth we might see a continuation of the problems you see with the $40 billion that we've heard on Medicare generally is fraud and abuse or double payment?

Mr. VLADECK. Well, we have—and, again, the Inspector General can probably speak in more detail about some of this—but over the last couple of years, we have learned some new techniques or rediscovered some old techniques in dealing with fraudulent providers of all kinds, including home care agencies, of which probably the two most relevant are: first, we are much quicker to totally suspend payment to providers once there's a creditable allegation of fraud than we have been in the past. And, second, particularly the U.S. Attorney in South Florida in Miami has been a particularly effective and aggressive user of a variety of civil recovery techniques to permit us to recapture payments that were made on a fraudulent basis to providers through putting various kinds of controls on bank accounts and other transfers of funds to limit the ability of providers to hide the money from us.

We still have a way to go which is why that in both the President's budget bill and separate legislation that we'll be introducing later this month, there are a number of other provisions that speak directly to the concerns about eliminating the bad apples from the barrel that have grown out of our experience over the last couple of years where we think statutory changes are needed. We'll be talking about these more, further, later in the month.

Mr. GREEN. So, there's an effort to exclude home health care providers who you have found a history of double payment or fraud?

Mr. VLADECK. Well, again, let me be very explicit—there is an effort to exclude all providers who are found to have committed a fraud against the Medicare or Medicaid programs, or other crimes that we think should disqualify them from participation in the program.

Mr. GREEN. I guess the concern I have is that it's one thing to be in a hospital setting and see the, you know, the treatment, but it's another thing particularly with the services provided in the home. In most cases there may not be direct physician oversight and I know that's another concern that we might hear about a little bit later.

Is there a percentage of audits, more audits maybe, on home health care as compared to other health care providers that do it in a facility, whether it be a clinic or a hospital?

Mr. VLADECK. I think probably the audit percentage is somewhat higher, but I want to speak to the particular question you just raised in two regards. One is our proposed new conditions of participation requirements for home care agencies are going to require criminal background checks on employees of home care agencies—we are asking for public comment on this proposal—and a variety of other ways of strengthening supervision requirements and otherwise protecting patients who are receiving services in the home.

The second piece of that broader issue is the need to again focus certain investigative efforts, and not only audits, but we're particularly proud of the way in which we have put together the work of our home health intermediaries who review claims to look at patterns of suspicious billing. Law enforcement agencies in the States and surveyors are actually going out to the home care agencies and into clients' homes to get them working together to share information, because we do find that very often there is a relationship between dubious financial practices and bad care. And so, by bringing

these two administrative processes together, we have been able to target some of the real bad problems in the industry.

Mr. GREEN. Mr. Chairman, I don't know how much time I have left or is it——

Mr. BILIRAKIS. A few seconds.

Mr. GREEN. Well, let me throw one thing out—again, home health care as compared to a facility or a physician, or another health care provider—it's so different because, again, the capital budget for a home health care agency is so little compared to a facility, and so again when you talk about the reimbursement rates and the auditing rates, it's so different from just checking a hospital, or checking a clinic, or checking another provider.

Mr. VLADECK. Again, our data don't entirely show it, but everything we know suggests that the larger, long-established, more professional home care agencies which have been connected to their communities, and to the health care system in their communities in a variety of ways over a period of time, display few problems. We have fewer problems—both on the financial side and the quality side—with well established agencies than we do with the very small, new agencies that keep popping up and disappearing in some parts of the country. We don't want to discourage new individuals from getting into business, and we don't want to discourage entrepreneuralism. What we need to do is to have some appropriate threshold to characterize an agency that has the resources, and the skills, and the expertise and the professionalism, to hold the agency accountable for the quality of care it's providing and for its financial reporting. That's the direction in which we need to go and our conditions for participation in the program.

Thank you, Mr. Chairman.

Mr. GREEN. Okay. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you Mr. Green.

Mr. Coburn has requested an additional minute to ask a basic question which I know you'll find significant. So, without objection, I recognize Mr. Coburn.

Mr. COBURN. Thank you, Mr. Chairman.

Mr. Vladeck, last year in the omnibus reconciliation package and the appropriation package that went through, there was a requirement placed on physicians to become responsible if, in fact, they sign off on home health care orders on patients that do not meet the requirements as they're now presented. There are just two parts to this question. No. 1, have you seen that this has lessened care for patients that should be getting care that aren't, and, No. 2, has that had any effect in slowing down fraud in terms of people receiving services, either not entitled or services being billed that were not performed?

Mr. VLADECK. I thank you for reminding me of that. My staff just sent me a note about that. It was contained in last year's legislation, and, again, I'll defer some of this to the Inspector General.

We have not fully implemented those provisions in the legislation yet, so we are going to be using that authority aggressively in the future, but we have not begun to do so. It's, therefore, too early to expect any significant changes as a result of that.

Mr. COBURN. When do you expect that to be implemented?

Mr. VLADECK. Again, some of the specifics I'll leave to the Inspector General, but certainly before we're too much further down the road in 1997.

Mr. COBURN. Thank you.

Mr. BILIRAKIS. Thank you. We have two more panels and I hesitate to go into another round. I don't feel that we should, but I know Mr. Burr has permission. I hope this is not creating a dangerous precedent.

Mr. BURR. Just one quick clarification on something, Mr. Chairman. I thank you.

Mr. Vladeck, under the interim payment system, it's my understanding that we do not provide an adjustment for the severity of the illness. Is that correct?

Mr. VLADECK. Under our proposed repayment system, that's correct.

Mr. BURR. Are you concerned that that might cause home health agencies to only solicit and supply care to the less sick, and, in fact, the more sick will be at risk?

Mr. VLADECK. Well, the caps are still on a very aggregated basis, and we're still paying essentially on a per-visit basis. Until we get a decent measure of case mix, we think per visit payment mechanism is a defense, although a very limited one, against that kind of selecting out of the harder patients.

Mr. BURR. But there——

Mr. VLADECK. So, there will be an aggregate cap at the agency level that at the margin will create a disincentive to take the harder cases, but, again, over a short period of time, given the base from which we are starting, we think that's a relatively modest risk. Over a long period of time, if you don't have a good case mix adjustment, any cap will create a risk of pushing the providers in the direction of easier patients. If the interim system were to become a permanent system, you'd have a real worry.

Mr. BURR. I thank you and I yield back to Mr. Chairman. Thank you.

Mr. BILIRAKIS. I thank you, gentlemen. Mr. Vladeck, thank you so much for your patience and your cooperation.

Mr. VLADECK. My pleasure and I imagine I'll see you again.

Mr. BILIRAKIS. I imagine you will.

The second panel consists of Mr. Michael F. Mangano, Principal Deputy Inspector General of HHS, and Mr. William Scanlon, Director of Health Financing Systems of HHS, and Mr. Donald Young, Executive Director of Prospective Payment Assessment Commission. Welcome, gentlemen. Dr. Young, we had the pleasure of your company just a couple of days ago.

Mr. YOUNG. Yes, sir.

Mr. BILIRAKIS. In the interest of time, I'll just maybe limit your testimony to 5 minutes, but, hopefully, we can get in one way or another whatever it is you care to communicate with us. Let's start off with Mr. Mangano.

STATEMENTS OF MICHAEL MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; DONALD A. YOUNG, EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING SYSTEMS, HEALTH, EDUCATION, AND HUMAN SERVICES, AND THOMAS DOWDEL, SENIOR ASSISTANT DIRECTOR, HEALTH FINANCING SYSTEMS, GAO

Mr. MANGANO Thank you, Mr. Chairman. I'm really pleased to be here this morning to talk about our work in this area which we think is one of the most vulnerable areas of Medicare today.

As you've heard earlier this morning, a lot of the explosive growth in this program has been attributed toward the skyrocketing increase in the number of services delivered to each beneficiary, as well as the increase in the number of beneficiaries themselves. Much of this increase in growth was expected as the population is aging and technological advances have brought more care to the local community. I'm sorry to report to you this morning that at least another important factor is the fraud and abuse factor.

We completed a series of audits in Florida, California, and Pennsylvania and we have found an error rate of between 19 and 64 percent. These errors represent services that were delivered to patients that were not homebound; services that were not medically necessary; services not rendered to the beneficiary, and services in which there was no physician certification for those particular services.

We undertook statewide reviews in New York, Texas, Illinois, and California, and we're finding on a statewide basis that those very same high rates of errors exist there as well. What troubles us most about this is the very wide disparity between the numbers of visits that some home health agencies deliver to their beneficiaries as opposed to others. We're finding that those home health agencies that have a low cost, those that are below the median for the industry, are providing about 33 services per beneficiary per year. This is a 1994 figure. Those on the high end are over a hundred.

We then went in and tried to figure out what's the difference between these two classes of the home health agencies, and I have to tell you that we were not able to find any factor that related to beneficiary characteristics or medical condition. That is, the age, race, gender had no effect, and the principal diagnosis, the medical condition which caused the person to be admitted for home health services, did not really vary between these two groupings. We did find some relationships between not-for-profit and unaffiliated organizations, but what we really believe is at the bottom of this is the opportunity for some home health agencies to really generate more home health services in cooperation with the people that they work with.

One of the problems in this industry is that the normal sets of brakes for abusive practices are not operative here. There are vulnerabilities that this benefit has that others don't. Let me just click off a few of those.

It's a benefit that's delivered in the home so the opportunity to supervise it is limited. There's no limit to the numbers of benefits—

numbers of visits that can be delivered to an individual patient. It's a cost-based system, so there's no incentive for the home health agency to limit the services to that which is the most appropriate level of services. You get, in fact, an incentive to do more services because you get paid more. And, finally, there's no co-pay here, so that the beneficiary doesn't have a pecuniary interest to try to put a break on unneeded services.

The key gatekeeper to this system is obviously the physician. When a physician sees his or her patient and assigns a plan of care and follows that patient through the delivery of these services, we find that the system works generally okay.

In our audits, we have found a number of instances where the physicians who ordered the home health services did not know the patient, did not physically examine the patient, and did not continue to monitor the patient as he/she went into care, and that's where the problems really surfaced.

We've offered in my testimony this morning a variety of different ways that we can begin to attack this problem and bring it back under control, things that we're trying to find—solutions that we're looking for—the ones that will protect the benefit, control expenditures, and minimize the opportunity for fraud and abuse.

In the administrative areas, I'd offer two that I mentioned in my testimony. One is to actually strengthen the role of the physician. There has been some discussion on that already, but we would ask that two more actions be required of the physicians. One, that we require the physician to actually examine the patient before assigning him a plan of care, and second, that the physician see that patient at least every 6 months thereafter. The physician can really maintain control of the needed plan of care for that particular beneficiary.

Second, is in the area of case management. We've looked at Medicaid, CHAMPUS, Veterans Administration, and the private sector, and found that case management techniques really do work. Some techniques involve limits on numbers of services and limits on beneficiaries. But the most effective techniques were those where case managers worked with physicians to determine the level of care that's needed and followed those patients through that level of care to ensure that they really got the services that would bring them back to health.

I will give you one example of that. Medicare-risk HMOs pay on an average of 25 percent of the costs that fee-for-service Medicare pays for an average beneficiary in the course of a year.

Let me just conclude my testimony by saying that we also see the possibility of a prospective payment system as a system that could take care of this in the future. The one caution that I would end with is that if we go to a prospective payment system, that we make sure that we don't grandfather in these skyrocketing utilization experiences that we are seeing in health agencies across the country.

Thank you very much, Mr. Chairman.

[The prepared statement of Michael Mangano follows:]

PREPARED STATEMENT OF MICHAEL MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good Morning, Mr. Chairman. I am Michael Mangano, Principal Deputy Inspector General, Department of Health and Human Services.

I am pleased to have this opportunity to summarize the results of our audits, inspections, and investigations on the Medicare home health program. Our office has done a considerable amount of work on this topic over the last several years. I hope this information will be useful to you in formulating legislation to deal with pervasive problems afflicting the home health program.

In summary, let me say that our work supports the need for prospective payment or other similar approaches for home health. Such systems are needed to prevent significant fraud, waste, and abuse that has arisen in this program and to control costs which are now almost uncontrollable. I wish to emphasize the immediacy of the need for action, and options to limit Medicare's exposure to losses while prospective payment systems are being developed.

Medicare Home Health Program. Medicare Part A pays for home health services for beneficiaries who are homebound, in need of care on an intermittent basis, and under the care of a physician who both establishes a plan of care and periodically reviews it. Beneficiaries receive numerous services including part-time or intermittent skilled nursing care; home health aide services; physical, speech and occupational therapy; medical equipment and supplies; and medical social services. The benefit is unlimited as long as the services are considered medically necessary.

Rapid Growth. All observers of Medicare's home health program are quick to describe its rapid growth. It is the fastest growing component of the Medicare program. FY 1996 expenditures are estimated to have been $16.9 billion, or five times the $3.5 billion spent in 1990. The number of beneficiaries increased from 2 to 3.7 million during this same period. Home health expenditures now account for 8.8 percent of total Medicare spending, compared to 3.5 percent in 1990. Utilization continues to rise from an average of 36 visits per Medicare beneficiary receiving home health benefits in 1990 to 72 visits in 1995, and an additional increase to 76 in 1996. The Congressional Budget Office has estimated that spending for home health services will reach $31 billion by 2002.

The reasons for the rapid growth of home health expenditures are well known—demographic trends, court cases which have liberalized coverage of the benefit, technological advances, such as infusion therapies, which can now be provided at home, a growing and aging Medicare population, and a trend toward providing more care in the community instead of institutions. Growth can be attributed to the fundamental structure of the benefit as well as problems with the management of it.

Fraud and Abuse. It is unfortunately true that fraud and abuse also play a significant role in the high growth rates of home health.

A synopsis of some of the investigative cases completed by the Office of Inspector General over the past two years illustrates the vulnerability of the Medicare program and the type of home health fraud and abuse it is exposed to.

- The Chief Executive Officer and his wife and co-owner at a Georgia home health agency were convicted of conspiracy to defraud Medicare. They were accused of filing cost reports that included personal expenses, political contributions, ghost employees and lobbying expenses. They were also charged with mail fraud, paying kickbacks, making false statements, witness tampering, money laundering, and submitting false tax returns. The defendants were sentenced to 90 months and 32 months incarceration, respectively. These individuals and the company will pay $255 million fines, restitutions, and other penalties.
- The owner of a Louisiana home health agency was sentenced to 5 years probation and ordered to repay $119,000 for defrauding the Medicare program. The owner included in Medicare cost reports the expenses of a costume shop she owned and a magazine she produced monthly. Expenses charged included payroll, leases, telephone service, and advertising.
- The owner of a Texas Home health agency entered a settlement agreement to pay $493,000 in civil damages and penalties for submitting false Medicare claims. Investigation found that over a 9-month period, the agency billed Medicare for home health services for patients that were not homebound, and for services not rendered.

These are not isolated examples. We have now completed audits of eight home health agencies in Florida, Pennsylvania, and California. These audits revealed agency error rates—the percent of the home health visits paid for by Medicare but which did not meet Medicare guidelines—from 19 to 64 percent. We found visits that were not reasonable or necessary, patients who were not homebound, visits which were not documented or even provided to Medicare beneficiaries, and im-

proper or missing physician authorizations. In a few cases we even found forged physician signatures. Preliminary data from Statewide audits underway in New York, Texas, Illinois, and California show similarly high error rates.

Unjustifiable Variation. We have also found extreme variation in payments to home health agencies. In FY 1993, lower cost home health agencies (those which provided less than the national average of visits per episode) averaged 30 visits per episode, whereas the higher cost agencies (those with visits per episode above the national average) provided 85. One year later, the lower cost agencies provided 33 visits per episode, while the average for the higher cost agencies jumped to 102.

We tried to find out what could account for the variation in the number of visits.

Beneficiary characteristics and medical condition did not account for it. We specifically examined beneficiary age, race, gender, deaths while in care, qualifying conditions, and principal diagnostic codes. We found nothing here to suggest that beneficiaries in the high-cost groups were any sicker or in any greater need of medical services than those beneficiaries in the low and middle-cost groups.

We also found no differences in the quality of care provided by home health agencies, as measured by the number of deficiencies and complaints recorded by HCFA's Survey and Certification Branch and the home health agencies' accreditation status. Providers in the higher cost group had about the same number of deficiencies as did those in the lower groups.

We did find that private for-profit home health agencies tended to be the more costly. Additionally, we found that home health agencies in four southeastern States—Tennessee, Alabama, Mississippi, and Georgia—averaged twice as many visits per Medicare beneficiary as home health agencies in all other States. These four States averaged approximately 100 visits per episode compared to approximately 54 for all other States.

It appears to us that other than the geographic difference, the differences are due mostly to the discretion afforded home health agencies to influence the amount of care given to their clients.

Looking for Solutions. Our work has shown repeatedly that there is a need for greater control and protection from fraud and abuse. However, we must proceed cautiously to ensure that any measures to control the benefit do not harm those beneficiaries who truly need these services. Our focus must be on protecting the benefit as well as controlling expenditures and minimizing the potential for fraud and abuse.

The logical places to establish controls are: 1) HCFA's Regional Home Health Intermediaries, first at the point of certifying providers to participate in the Medicare program, and later when reviewing bills submitted for payment; 2) physicians authorizing the plan of care; 3) the beneficiaries receiving the care; and 4) the service providers.

Unfortunately, the volume of new providers entering the market and the volume of claims to be processed have made it extremely difficult for HCFA's intermediaries to scrutinize provider applications and bills as much as is needed to prevent fraud, waste, and abuse. HCFA is now developing new conditions of participation which may help prevent problem providers from entering the program; but the volume of claims will remain a problem for some time to come.

Physicians' involvement in home health care is inconsistent. Our studies have shown that they are typically involved in initial referrals of patients for home care, approving plans of care, and monitoring progress of complex patients. However, they are less involved in continuing monitoring of beneficiary eligibility, coordinating services, determining medical necessity of services, visiting patients at home, and participating in interdisciplinary conferences.

Likewise, Medicare beneficiaries have limited involvement in controlling home health services they receive. Many beneficiaries, while satisfied with the home health care they receive, do not understand what Medicare paid for. Furthermore, they have no financial liability or responsibility for the services. Therefore, beneficiaries have little incentive to control services.

Most home health service providers are dedicated to caring for their clients. They have not increased their visits just to maximize profits, but have focused on the needs to the beneficiaries under their care. Unfortunately, for unscrupulous providers, the current cost-based reimbursement systems does not provide incentives for providers to properly manage costs. In fact, it does just the opposite. Cost-based reimbursement provides incentives to increase revenues by providing more visits. Theoretically, home health agencies cannot themselves authorize home health visits. However, they can be very influential is obtaining certification from physicians.

To learn more about how costs can be controlled, we examined practices of private insurance companies, State Medicaid agencies, the Department of Veterans Affairs, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS),

and numerous health maintenance organizations (HMOs). While their benefit structures were similar to Medicare's, they did try to control costs in ways that Medicare does not. For example, some place limits on the number of visits or caps on the dollar amount that can be paid. Many tried to target their programs more specifically to the individualized needs of their beneficiaries. They also undertook more intensive utilization control measures such as reviews of physician referral rates, post-pay edits, and utilization profiling combined with physician education.

We found that HMO's provide home health care for only one-fourth the cost of the Medicare fee-for-service program. The HMOs that responded to our survey spent an average of $882 per beneficiary in 1994 compared to Medicare's fee-for-service cost of $3,464. They do this by using case managers to review and approve patient care. These case managers work with physicians to plan care and write orders, review and approve both initial and continuing visits, review medical necessity, track and report outcomes and cost savings on a monthly basis, and participate in quality assurance activities such as clinical record reviews, team meetings, and case conferences. They carefully control both the number and kind of visits, constantly evaluating the care provided.

Administrative Remedies. HCFA has already begun to take administrative action to address problems which we have described here. As mentioned earlier, a new set of conditions of participation is under development. HCFA has also strengthened the role of its Survey and Certification teams by asking them to look for financial abuses during the surveys. HCFA has recently started issuing a Notification of Utilization (similar to the Explanation of Medical Benefits used for other Medicare bills) to inform patients of the services billed on their behalf, and in other ways is reaching out to educate both beneficiaries and physicians about their roles in preventing abusive billing.

Additional steps can also be taken. Based on private sector practices and on our own analysis of weaknesses which we found, we have made several recommendations aimed at controlling Medicare expenditures and reducing the potential for fraud, waste and abuse. These include:

Focused HHA Reviews: Target the HHAs with average reimbursement higher than a standard established by HCFA for closer scrutiny by the Survey and Certification Branch as well as reviews by the Regional Home Health Intermediaries.

Regional Home Health Intermediary Resources and Flexibility: Ensure that Regional Home Health Intermediaries have adequate resources and tools to review applications for providers wishing to participate in the Medicare program and to detect and act on claims they suspect are fraudulent or abusive.

Case Management: Fund case management programs in the fiscal intermediaries. Case managers would be used to monitor and manage cases that reach a trigger point, or benefit threshold.

Beneficiary Certification: Require beneficiaries to certify their "homebound" status.

Stronger Physician Role: Require physicians to examine the patient before they order home health service. Require the patient to see the certifying physician at least once every 6 months.

Legislative Changes. However, we believe that management actions like these will not be sufficient. The problems are so commonplace that a restructuring of Medicare's payment system is called for. Options include:

Prospective Payment System: Establish a per episode prospective payment system. This may be the most effective long-term model for restructuring the benefit. We encourage HCFA to continue their work in testing such a system. We believe, however, that it is important that a new system not "grandfather" in utilization patterns of the higher-reimbursement agencies. It is worth noting that this was an important issue when a prospective payment system was being developed for hospitals.

Cap on Number of Visits Per Beneficiary: Limit the number of visits that Medicare will pay for any one beneficiary per year, or per episode. This would be similar to the approach Medicare takes for skilled nursing facilities.

Cost Limits Per Beneficiary: Develop a cost ceiling, limiting the amount payable in a given period for home health benefits on behalf of a beneficiary. The period to which the limit could apply might be lifetime, annual, or episodic. This is similar to a prospective payment system, except that it provides a cap rather than a fixed fee for services rendered. Also, the cap may or may not vary according to the diagnosis or treatment of the patient.

Visit Parameters Based on Condition: Set parameters on the number of visits a beneficiary may receive for a specified condition. When that parameter is

reached, an additional set of conditions, documentation, or justification would be required to obtain reimbursement for additional visits.

Benefit Targeting: This is similar to the preceding option, but goes further by considering not only the number of visits authorized, but also the types of visits. Medicare might wish to channel patients with different needs (e.g., chronic vs. acute care patients) into different home health "programs", with different kinds of treatments, to create better, more appropriate care and greater program controls.

Limit on Average Number of Visits Per Beneficiary for Each Home Health Agency: Develop an average number of visits per beneficiary which HHAs may provide in a year. Beneficiaries who need a large number of visits would be offset by those who need very few visits. This budget would need to be flexible enough to allow for hardship cases, which warrant an unusually high number of visits, and/or adjusted for case mix.

Limit on Average Cost Per Beneficiary for Each Home Health Agency: This is the same as the preceding proposal, except that costs rather than visits would be used as the limiting factor.

Beneficiary Copayments: Require beneficiary copayments as a way to give them a stake in home health billings and to further ensure that unnecessary services are not provided. A copayment could begin upon admission or after a certain number of visits. This would create an incentive for patients and families to reduce over utilization. Medicare uses co-payments or other forms of co-insurance for most of its benefits.

Given the current rapid growth rate, it is important to take action quickly. If the goal is to establish a prospective payment system, and if that cannot be done immediately, we suggest that one or more of the approaches outlined above be used in the interim.

CONCLUSION

I appreciate the opportunity to appear before you today and share with you some of our work and recommendations related to Medicare home health services. I would be happy to respond to any questions you may have.

Mr. BURR [presiding]. Thank you. Dr. Young?

STATEMENT OF DONALD A. YOUNG

Mr. YOUNG. Thank you very much, Mr. Chairman. I'm going to be speaking from some charts that are appended to the end of my testimony.

In chart 1 we display the growth in the home health care payments. As you can see, this growth as been primarily in Part A, but for those beneficiaries who are eligible for Part B, the rate of growth has been just as large under Part B of the Medicare program as it has been under Part A.

As shown in chart 3, the spending growth is being driven both by the number of people being served and by increases in the number of visits per each person that is being served. Between 1990 and 1996, the number of people being served with home health services doubled and now over 10 percent of the Medicare population in the fee-for-service program is receiving home health benefits. And, during this time the number of visits per person served more than doubled.

The growth in the number of people served and the number of visits they received is due, in part, to the very vague and limited constraints which are currently in place for the benefit. The open-ended nature of the home health benefit, together with Medicare's cost-based reimbursement policies have attracted new marked entrants into the home health care field.

As you can see in chart 4, between 1990 and 1996 the number of Medicare-certified home health agencies increased 71 percent.

And, of particular interest is the very rapid growth in hospital-based home health agencies.

Chart 5 shows that the nature of the home health care benefit has also changed substantially in recent years. The types of services that are being furnished is changing. In 1988 two-thirds of all home health visits were provided by skilled nursing or other skilled personnel, and one-third of the visits involved home health aides. By 1994, the share of skilled and home health aide visits were just about equal.

It's also important to note that most home health visits are not preceded by a hospital stay, although 14 percent of Medicare PPS hospital discharges are followed by home health use within 30 days. These patients account for only a small share of all visits.

A recent PROPAC analysis revealed that 85 percent of all Medicare-covered home health visits in a given month did not follow a hospital stay within 30 days, and in fact, 50 percent of all visits did not have an associated hospital stay within a year.

As you can see in chart 6, the use of home health care shows two very distinct patterns. Half of all Medicare beneficiaries using home health care received less than thirty visits and these people together account for only 10 percent of all Medicare visits. By contrast, 12 percent of home health users had 150 or more visits in a year—as many as 3 every 4 days. And, this 12 percent of users accounted for more than half of all Medicare's home health visits.

There are a number of reasons for this extraordinary growth in home health spending and utilization. First, the home health benefit is vaguely defined. The definition of homebound is very difficult to enforce. There are few criteria to use to assess the need for skilled care, and I'm certain that this is one of the problems that confronts the physicians. What are the criteria for skilled care? What are the criteria for frequency regarding the use of this skilled care to remain eligible? Remaining eligible for skilled care is critical to receive home health aide services. And, there's no definition of a home health visit. The Medicare program does not know what it is buying for a visit.

Second is cost-based reimbursement and all of its incentives, and third, in contrast to other Medicare Part A services, there is no limit on the number of visits and no beneficiary cost sharing requirements.

PROPAC has just submitted its annual report to you, and in that report we include a number of recommendations to improve Medicare's home health policies. We recommend that Congress should more specifically examine and address the scope of Medicare's home health benefit. We support a case mix adjusted prospective payment for home health agencies, and believe this should be implemented as soon as possible. We also stress the need for Congress to implement an interim payment system to control Medicare outlays until a fully developed prospective payment system can be put in place.

We recommend that Medicare should require consistent home health visit coding and we support beneficiary copayments which are very modest in amount for home health services. We also recommend that the Secretary should further analyze the growth in the number of beneficiaries who are receiving home health services

for long periods of time and review additional policies that may be needed to address the spending associated with these.

And, that concludes my statement, Mr. Chairman.

[The prepared statement of Donald A. Young follows:]

PREPARED STATEMENT OF DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good morning, Mr. Chairman. I am Donald Young, M.D., Executive Director of the Prospective Payment Assessment Commission (ProPAC). I am pleased to be here to discuss Medicare's policies for home health care agencies. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

As you know, Mr. Chairman, payments to home health agencies are one of the fastest growing components of the Medicare program. Between 1990 and 1996, total home health payments increased five-fold, from $3.5 billion to $17.7 billion (see Chart 1). Home health spending has grown from 6 percent of total Part A spending in 1990 to 14 percent in 1995. While spending has slowed somewhat in the past two years, the Congressional Budget Office projects that payments to home health agencies will continue to rise faster than overall Medicare spending between now and 2002.

The dramatic rise in home health spending is due to increases in both the number of beneficiaries receiving services and the number of visits they receive. While Medicare has modified its policies over the years to slow the growth in payments per visit, its ability to control the number of visits provided has remained elusive. As I will describe in a moment, this is due in part to deficiencies in current coverage and payment policies.

In the Commission's most recent *Report and Recommendations to the Congress,* which we released on Monday, ProPAC makes a number of recommendations to improve Medicare's payment policies for home health care and control spending increases. This morning, I would like to discuss those recommendations. But first, I would like to briefly summarize the home health care benefit and reasons associated with its growth.

The Home Health Benefit

Home health care may be covered under Medicare Part A or Part B. Beneficiaries enrolled in both Parts A and B—about 95 percent of the Medicare population—receive home health care under Part A. Beneficiaries who are not eligible for Part A but are enrolled in Part B receive home health care under Part B.

To qualify for the home health benefit under either Part A or Part B, a beneficiary must be homebound and under the care of a physician who prescribes intermittent skilled nursing services, or physical or speech therapy. The physician must review and re-sign the care plan at least every 62 days for a beneficiary to continue receiving services. Once authorized, beneficiaries may also receive home health aide services, occupational therapy, or medical social services. Beneficiaries pay no coinsurance or deductibles for home health visits, and there are no program limits on the number of visits they may receive.

Medicare beneficiaries receive home health services from a Medicare-certified agency. The agency may be part of a hospital or other facility, or may be an independent free-standing organization. Medicare pays these agencies the lower of their costs or a limit. The limits are based on 112 percent of the average cost per visit for free-standing agencies for each of the six visit types, computed separately for urban and rural areas (see Chart 2). Medicare does not specify the duration of a visit; therefore, the limits reflect varying visit lengths across and within individual agencies.

Although the limits are computed at the service level, they are applied to aggregate agency costs. The result is an aggregate payment limit for each agency that equals the limit for each type of service multiplied by the corresponding number of visits.

The Growth in Home Health Payments

As I mentioned earlier, the growth in home health spending is mainly a result of increases in the number of visits provided rather than increases in payments per visit. This utilization growth, in turn, has been associated with changes in Medicare's home health policies.

For many years, home health expenditures accounted for a small share of total Part A spending, reaching about 2 percent in 1980. Before 1980, beneficiaries could receive home health care under Part A but only if they had a three-day prior hos-

pitalization. They also were limited to 100 visits. If the beneficiary required more than 100 visits and was eligible for Part B, they could receive an additional 100 visits, so long as they met the applicable deductible. Beneficiaries who did not have a prior hospitalization or were not eligible for Part A benefits could receive up to 100 visits under Part B, again so long as they paid the deductible.

The Omnibus Budget Reconciliation Act of 1980 eliminated the hospital stay requirement under Part A, the deductible requirement under Part B, and the 100 visit limit under both Parts A and B. This resulted in a jump in utilization. In response, the Health Care Financing Administration (HCFA) used administrative means to tighten the coverage criteria. Over the next several years, increases in home health payments were relatively small, and the number of people served as well as the number of visits per person remained relatively stable. HCFA's actions, however, spurred a legal challenge in 1988. The court ruled that HCFA's actions were contrary to legislative intent under the Medicare law. In response, HCFA loosened its coverage requirements.

After this decision, the number of beneficiaries receiving home health care and the number of visits they received spiralled. Between 1989 and 1996, the number of beneficiaries receiving home health more than doubled, from about 1.6 million to 3.7 million. The number of visits the average user received per year nearly tripled over this period, from 26 to 76 (see Chart 3).

Cost-based reimbursement combined with few constraints on utilization have attracted new entrants into the home health care market, which also has contributed to utilization growth. Between 1990 and 1996, the number of agencies grew by 71 percent to reach 9,886 (see Chart 4). The supply of free-standing and hospital-based facilities rose at about the same rate.

The growing use of home health services has been associated with changes in the mix of services provided. Skilled nursing and home health aides represent the bulk of home health visits. Home health aides furnish personal care services (such as bathing, dressing, and grooming), simple wound dressing changes, and assistance with medications. In 1988, skilled nursing services represented the larger share of visits provided, 51 percent of the total compared to 34 percent for home health aides. In 1994, however, home health aide visits were more prevalent, accounting for 48 percent of visits compared to 42 percent for skilled nursing services (see Chart 5).

The bulk of home health visits are not associated with a hospitalization. A recent ProPAC analysis revealed that while 60 percent of home health episodes—defined as a group of visits preceded and followed by a 60 day period without visits—were preceded by a hospital stay, 85 percent of home health visits in a given month did not follow a hospital stay within 30 days of the visit and about 50 percent of visits were received by beneficiaries who did not have a hospitalization within the previous year.

Beneficiaries' use of home health care reveals two distinct patterns. ProPAC analysis of fiscal year 1994 data shows that half of beneficiaries who received home health care received fewer than 30 visits. These visits were generally provided over a short period, and the majority of them were for skilled nursing services. By contrast, 12 percent of home health users had 150 or more visits (see Chart 6). These users tended to receive home health care over long periods of time, sometimes a year or more, and to receive more home health aide visits.

This small group of beneficiaries receiving large amounts of visits account for the bulk of home health use. In 1994, they accounted for slightly more than half of all visits and two-thirds of all home health aide visits. These individuals are likely to be older or disabled.

ProPAC's Home Health Recommendations

Controlling spending for home health care is especially challenging because of the need to control service usage. In turn, controlling utilization is complicated because of broad coverage guidelines and wide variations in treatment protocols. To help gain insight into long-term use patterns, the Commission recommends that the Secretary analyze the factors associated with long-term use to determine whether additional policy changes may be desirable.

In addition to this recommendation, ProPAC believes a number of changes should be made to improve the home health benefit and control spending increases. These focus on more clearly defining the benefit, implementing changes to the payment system, and having beneficiaries share in the financial responsibility for home health services. I would like to summarize each of these recommendations.

Defining the Home Health Care Benefit

One of the difficulties in constraining home health spending is the existence of broad coverage guidelines that allow for prolonged service use by an increasing number of beneficiaries. Beneficiaries qualify for home health services if they are homebound and under the care of a physician who prescribes intermittent skilled nursing care or physical or speech therapy. The homebound requirement is not very restrictive and is difficult to enforce. The physician certification requirement is a weak restraint at best, partly because there are no specific criteria to guide physicians' determinations of the need for skilled services.

Currently, the Medicare program is paying for what appear to be two different types of benefits. One covers care that is of short duration and is heavily weighted to skilled services. The other covers longer-term care that is weighted towards home health aide services.

The Commission believes that the Medicare program has a responsibility to ensure that the services it pays for are reasonable, necessary, and medically appropriate. The lack of a clearly defined benefit compromises the ability to carry out this responsibility. Defining the appropriate use of home health services more clearly could help constrain home health spending while allowing the Medicare program to continue to meet the needs of its beneficiaries.

Prospective Payment

The Commission believes that the current cost-based payment per visit method should be replaced by a prospective payment system. Prospective payment could slow the growth in home health expenditures and encourage providers to deliver services in a more efficient manner. To be effective, however, the payment must cover more than an individual visit. Ideally, the program should pay for all services furnished over a period of time. Defining this period is difficult, however, because in the home setting it is hard to identify when an appropriate period of treatment begins and ends. In turn, this is complicated because of the lack of a clear definition of the home health benefit, or of the nature of the home health visit.

An additional difficulty in implementing prospective payment is the lack of an adequate case-mix classification system. Such a system is needed to account for variations in patients' needs. Payments should be higher for patients with greater resource needs and lower for those who require less care. The ability to adjust prospective payment rates for differences in case mix is critical to ensuring fair payment to providers and access to services for patients. Without an adequate case-mix adjustment, prospective payment could unduly reward providers that treat low-cost individuals and penalize those that treat patients with more complex needs.

Developing a case-mix system is a challenging task generally, but it is especially difficult in the home health arena where patients' service needs often depend on multiple factors. For example, functional status and social support needs may be more important than diagnosis in predicting resource requirements for home health patients.

We understand that HCFA is in the preliminary stages of developing a new case-mix system. This system, however, will not be ready for several years. In the meantime, the Commission believes that an interim system should be implemented immediately to stem rising expenditure growth. I would like to discuss several of the Commission's views on such a system.

An Interim Payment System

An interim payment system should specify per visit payments and limit total home health payments for beneficiaries. For the short term, per visit payments could continue to be based on the current method of agency-specific costs subject to a per visit limit. This method can effectively constrain per visit payments, although it continues the link between costs and payments, contrary to the premise of prospective payment. Alternatively, establishing prospective per visit payment rates could begin the transition away from cost-based payments. Separate rates for each home health service could be calculated using agency-specific costs, national average amounts, or a blend of the two. Either method would reward facilities for keeping their costs per visit below the payment amount.

As I mentioned earlier, however, a home health visit is not uniformly defined. Therefore, agencies could simultaneously reduce their costs and increase revenues by shortening visits and providing more of them. I should note that the Commission also recommends that Medicare require consistent home health visit coding. This would permit home health usage to be monitored and evaluated over time. This information also is necessary to develop an effective case-mix adjustment system.

Beneficiary payment limits would dampen the incentive to provide more visits because such limits would encourage home health agencies to control the number of visits and adjust the mix of services furnished to each user. The limits could be associated with payments for services provided over a specific period, such as a year or a month. An annual limit would constrain use for those beneficiaries who use services for a long period of time. Given that most visits are associated with these users, this might be an appropriate course of action. Shorter time periods would affect service use for almost all Medicare patients, although agencies could respond by spreading visits over a longer period to reduce the likelihood that payments for a beneficiary would reach the limit in the given time frame.

Beneficiary limits could be calculated based on agency-specific costs, national average expenditures, or a blended amount. The limits could be applied to an agency's aggregate payments or to spending for individual patients. Regardless of the method chosen, an outlier payment mechanism similar to that under Medicare's Prospective Payment System for acute care hospitals could be incorporated to minimize incentives to avoid high-cost cases.

Home Health Copayments

Mr. Chairman, with the exception of lab services, home health is the only Medicare benefit not subject to beneficiary cost-sharing. The Commission believes it is both appropriate and fair to impose modest copayments, subject to annual limits, for home health care visits.

With copayments, patients would share financial responsibility for services with the program. Although many beneficiaries have some form of supplemental insurance or Medicaid coverage that could cover these outlays, copayments could curb use by involving beneficiaries more in treatment decisions and making them more aware of service costs. Copayments also might limit fraudulent billing practices, since beneficiaries could identify services for which Medicare was billed but that were not delivered.

Conclusion

Payments for home health care services are growing out of proportion compared to the rest of the program. The Commission believes its recommendations to reform coverage and payment policies are necessary to constrain spending while ensuring quality care for Medicare beneficiaries.

This completes my formal testimony, Mr. Chairman. I would be pleased to answer any questions from you or other members of the Subcommittee.

Chart 1. Medicare Home Health Program Payments, Fiscal Years 1983-1996

Year	Payments (In Billions)			Percent Change
	Part A	Part B	Total	
1983	1.50	0.02	1.52	–
1984	1.78	0.03	1.81	19.1
1985	1.91	0.03	1.94	7.2
1986	1.92	0.03	1.95	0.5
1987	1.88	0.03	1.91	–2.1
1988	2.00	0.04	2.04	6.8
1989	2.32	0.04	2.36	15.7
1990	3.43	0.09	3.52	49.2
1991	5.57	0.07	5.19	47.4
1992	7.25	0.06	7.31	40.8
1993	9.64	0.11	9.75	33.4
1994	12.56	0.11	12.67	29.9
1995*	15.66	0.21	15.87	25.3
1996*	17.47	0.24	17.71	11.6

Note: Payments are incurred expenditures rather than outlays.
*Estimated.
SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 2. Home Health Agency Cost Limits Per Visit

Type of Visit	Urban	Rural
Skilled nursing care	$98.19	$109.62
Physical therapy	107.43	119.65
Speech pathology	107.99	130.61
Occupational therapy	107.25	129.30
Medical social services	142.05	184.03
Home health aide	47.70	47.60

Note: These values represent per visit limits for cost reporting periods beginning on or after July 1, 1996. Limits are equal to 112 percent of costs for freestanding home health agencies. These limits are adjusted by area-specific wage indices and a budget neutrality adjustment to arrive at area-specific limits.
SOURCE: **Medicare Program: Schedule of Limits on Home Health Agency Costs Per Visit** 61 Federal Register 34344 (July 1, 1996).

Chart 3. Medicare Part A Home Health Use, 1983-1996

Year of Service	People Served		Visits		
	Number (In Thousands)	Percent Change	Number (In Thousands)	Percent Change	Per Person Served
1983	1,277	–	35,683	–	28
1984	1,446	13.2	39,745	11.4	27
1985	1,536	6.2	39,892	0.4	26
1986	1,566	2.0	38,537	-3.4	25
1987	1,551	–1.0	36,045	-6.5	23
1988	1,573	1.4	36,382	0.9	23
1989	1,641	4.3	42,522	16.9	26
1990	1,876	14.3	62,765	47.6	33
1991	2,152	14.7	91,180	45.3	43
1992	2,448	13.8	126,547	38.8	52
1993	2,782	13.6	159,597	26.1	57
1994	3,099	11.4	207,030	29.7	67
1995*	3,470	12.0	257,847	24.5	74
1996*	3,700	6.6	280,842	8.9	76

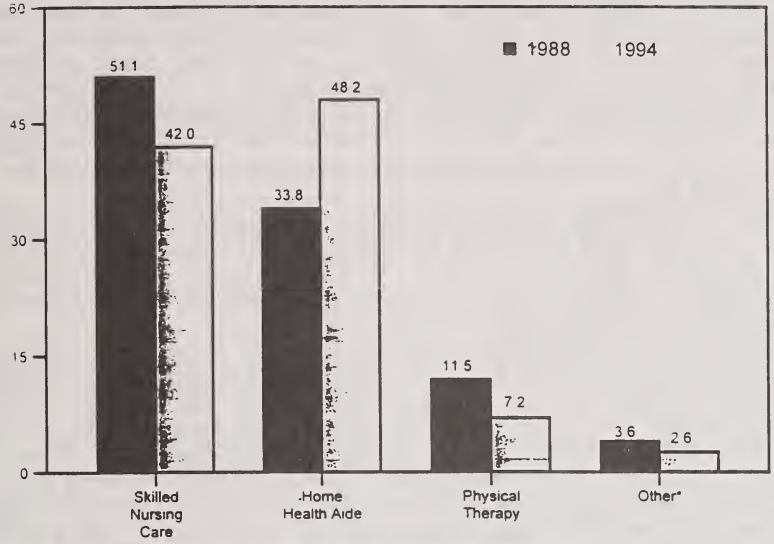
Estimated.
SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 4. Medicare-Certified Home Health Agencies, 1990-1996

Agency Type	1990	1992	1994	1996	Percent Change 1990-1996
Total	5,793	6,419	8,057	9,886	71
Freestanding	4,135	4,526	5,720	7,104	72
Hospital-based	1,658	1,893	2,337	2,782	68

Note: Data are as of December each year.
SOURCE: Health Care Financing Administration, Office of Survey and Certification.

Chart 5. Share of Home Health Visits, by Type of Service, 1988 and 1994 (in Percent)



*Includes speech therapy, occupational therapy, medical social services, and other health disciplines.
SOURCE: Medicare and Medicaid Statistical Supplement, 1996 Health Care Financing Review, 1996 Statistical Supplement.

Chart 6. Home Health Visits Per User, Fiscal Year 1994

Number of Visits Per User	Percent of Total				Average Number of Visits Per User
	Users	Visits	Skilled Nursing Visits	Home Health Aide Visits	
1-9	23.0	1.8	3.2	0.3	5
10-29	30.2	8.5	13.1	2.7	18
30-49	13.4	8.1	10.9	4.4	38
50-99	14.5	16.0	18.8	11.9	70
100-149	6.6	12.6	12.2	12.8	122
150+	12.3	53.1	41.7	67.9	275
Total	100.0	100.0	100.0	100.0	64

SOURCE: ProPAC analysis of a 20 percent sample of home health claims data from the Health Care Financing Administration.

Mr. BURR. Thank you, Mr. Young.
Mr. Scanlon?

STATEMENT OF WILLIAM J. SCANLON

Mr. SCANLON. Thank you, Mr. Chairman and members of the subcommittee. I'm very pleased to be here today as the subcommittee reviews the Medicare home health benefit and the administration's proposals for reform of it. With me today is Thomas Dowdel, a Senior Assistant Director at the General Accounting Office who is responsible for our home health study which was issued in a report last year.

As you've heard from previous witnesses, after some relatively modest growth in this benefit in the 1980's, it has become one of the fastest growing benefits in the Medicare program in the 1990's, and while there have been a number of policy changes over the years that influence this benefit directly or indirectly, it was the change in the covereage guidelines in 1989 that was the trigger for

these rapid increases. I would contrast that experience with the period following the introduction of prospective payment for hospitals in 1983 where, despite expectations that hospitals would respond to the incentive to discharge patients sooner and many patients would receive continuing services at home, there were surprisingly moderate increases in Medicare's home health spending. That came about, in part, because Medicare increased the amount of oversight of home health claims to assure that only appropriate services were being paid for.

The Consolidated Omnibus Budget Reconciliation Act of 1985 more than doubled the funds available for medical review and audits of home health and other Medicare claims. Intermediaries were able to conduct medical reviews of 62 percent of home health claims in fiscal years 1986 and 1987.

Following the reissuance of the home health coverage guidelines, but not directly related to it, the resources for program oversight began to decline. The simultaneous increase in the number of submitted claims after the guideline changes resulted in less than 3 percent of home health claims being reviewed last year. The increase in claims at the time review was declining is clearly one of the factors that led to the concern of Dr. Vladeck that a significant portion of claims are inappropriate which contribute to the growth that we are witnessing.

As you consider the possible adoption of prospective payment as a means of controlling home health spending growth, citing this history is important for two reasons. First, the state-of-the-art of understanding home health care and designing an effective prospective payment system is not developed enough to rely on the payment system alone to achieve the objectives of controlling spending while preserving service quality. There will need to be a complementary effort in the area of appropriate and adequate oversight in order to pursue these goals. Mr. Vladeck has indicated a number of initiatives in this regard in his statement. While we have not had the opportunity to review HCFA's plans in detail, we support the intent of these efforts.

The second reason for bringing up this history of home health under Medicare is that the enactment of the Health Insurance Portability and Accountability Act last year reversed the trend in terms of oversight funding by increasing the funding available in future years. It is important that an appropriate share of those funds support oversight for this high risk service.

Let me turn now to the design of the prospective payment system for home health. We agree with Mr. Vladeck regarding the need for an episode-based prospective payment system. The routine cost limits, which have been in place for many years for home health payments, operate as a quasi-per-visit prospective rate for a large share of agencies. These limits have not succeeded in controlling spending, because the number of beneficiaries receiving services and the number of services per beneficiary have more than doubled since 1990.

Payment for an episode of care, such as care for a 30-or 100-day period, creates a risk, though, that the incentive to control resources will result in too few visits and lower quality of care. While paying for episodes may better control spending, HCFA will need

a method to ensure that beneficiaries receive adequate services and that any reduction in services that can be accounted for by past over-provision of care does not result in windfall profits to agencies. In addition, HCFA would need to be vigilant to ensure that patients meet coverage requirements because prospective payment on an episode basis gives agencies an incentive to increase their caseloads.

In implementing a prospective payment system, we have concerns also about the adequacy of HCFA's home health cost and utilization data as a basis for setting rates. A good design of a payment system can be overwhelmed by bad data. Cost report audits are the primary means available to ensure that home health agencies' cost reports reflect only allowable costs. But, the percentage of agencies that have had field audits has decreased, as has the thoroughness of any conducted audits. We think it would be prudent for HCFA to do a thorough audit of a projectable sample of agency cost reports, so that the results can be used to adjust the cost report data bases to help ensure unallowable costs are not used as a basis for prospective rate setting.

We are also concerned about the appropriateness of using current Medicare data on the frequency of visits to establish prospective rates. As I've noted, controls over the use of home health care are virtually non-existent. We believe it would be prudent for HCFA to conduct thorough onsite medical reviews for a projectable sample of agencies to give it a basis to adjust utilization rates for the purposes of again setting prospective payments.

In conclusion, it's clear that the current payment system for providers of home health services to Medicare beneficiaries needs to be revised. As more details concerning the administration's or other proposals for revising the system become available, we would be happy to work with you and others on the implications of the suggested revisions. Thank you very much.

[The prepared statement of William J. Scanlon follows:]

PREPARED STATEMENT OF WILLIAM J. SCANLON, DIRECTOR , HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GAO

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today to discuss Medicare's home health care benefit and the administration's forthcoming legislative proposals related to it. After relatively modest growth during the 1980s, Medicare's expenditures for home health care have grown rapidly in the 1990s. Home health care costs grew from $2.4 billion in 1989 to $17.7 billion in 1996, an average annual increase of 33 percent.

My comments will focus on the reasons for cost growth for home health care and the administration's announced legislative proposals for this Medicare benefit. The information presented is based mainly on our previous work. We also examined recent data on the benefit from the Health Care Financing Administration (HCFA), which manages Medicare. The detailed legislative proposals are not yet available from the administration, so we reviewed the summaries of them that have been publicly released and talked with HCFA officials about these summaries.

In brief, Medicare's home health care costs have grown because a larger portion of beneficiaries use this benefit than in the past and the number of services used by each beneficiary has more than doubled. A combination of factors led to the increased use of the benefit:

—legislation and coverage policy changes in response to court decisions liberalized coverage criteria for the benefit, enabling more beneficiaries to qualify for care;
—these changes also transformed the nature of home health care from primarily posthospital care to more long-term care for chronic conditions; and

—a diminution of administrative controls over the benefit, resulting at least in part from fewer resources being available for such controls, reduced the likelihood that inappropriate claims would be detected.

The major proposals by the administration for home health care are designed to give providers increased incentives to operate efficiently by immediately tightening the limits on the amount of cost per visit that will be paid and imposing a new cap on per-beneficiary costs. After these changes, in 1999, the proposal would move home health payments from cost reimbursement to a prospective payment system (PPS). Estimated savings from these two proposals are $12.4 billion over the next 5 fiscal years. What remains unclear about the reasonableness of the PPS proposal is whether an appropriate unit of service for calculating prospective payments can be defined and whether HCFA's databases are adequate for it to set reasonable rates.

BACKGROUND

To qualify for home health care, a beneficiary must be confined to his or her residence ("homebound"); require part-time or intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a physician; and have the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits. Beneficiaries are not liable for any coinsurance or deductibles for these home health services, and there is no limit on the number of visits for which Medicare will pay.

Medicare pays home health agencies on the basis of their reasonable costs—those that are found to be necessary and related to patient care—up to specified cost limits. Home health agency cost limits are set separately for agencies in rural and urban areas, at 112 percent of the mean costs of freestanding agencies. Hospital-based agencies have the same limits. Separate limits are set for each type of visit (skilled nursing, physical therapy, and so on) but are applied in the aggregate; that is, costs over the limit for one type of visit can be offset by costs below the limit for another. Home health cost limits are adjusted for differences in wage levels across geographic areas. Also, exemptions from and exceptions to the cost limits are available to home health agencies that meet certain conditions.

While the per-visit cost-limit provision of Medicare's reimbursement system for home health agencies gives some incentives for providers to control their costs, these incentives are considered by health financing experts to be relatively weak. For providers with per-visit costs considerably below their limit, there is little incentive to control costs, and for all providers, there is no incentive to control number of visits. It is generally agreed that prospective payment systems give providers increased cost-control incentives.

HOME HEALTH COST GROWTH

The Medicare home health benefit is one of the fastest growing components of Medicare spending. From 1989 to 1996, part A expenditures for home health increased from $2.4 billion to $17.7 billion—an increase of over 600 percent. Home health payments currently represent 13.5 percent of Medicare part A expenditures.

At Medicare's inception in 1966, the home health benefit under part A provided limited posthospital care of up to 100 visits per year after a hospitalization of at least 3 days. In addition, the services could only be provided within 1 year after the patient's discharge and had to be for the same illness. Part B coverage of home health was limited to 100 visits per year. These restrictions under part A and part B were eliminated by the Omnibus Reconciliation Act of 1980 (ORA, P.L. 96-499), but little immediate effect on Medicare costs occurred.

With the implementation of the Medicare inpatient hospital PPS in 1983, the utilization of the home health benefit was expected to grow as patients were discharged from the hospital earlier in their recovery periods. However, HCFA's relatively stringent interpretation of coverage and eligibility criteria held growth in check for the next few years. As a result of court decisions in the late 1980s, HCFA issued guideline changes for the home health benefit that had the effect of liberalizing coverage criteria, thereby making it easier for beneficiaries to obtain home health coverage. Additionally, the changes prevent HCFA's claims processing contractors from denying physician-ordered home health services unless the contractors can supply specific clinical evidence that indicates which particular services should not be covered.

The combination of these legislative and coverage policy changes has had a dramatic effect on utilization of the home health benefit in the 1990s, both in terms of the number of beneficiaries receiving services and in the extent of these services.

(App. I contains a figure that shows growth in home health expenditures in relation to the legislative and policy changes.) For example, ORA 1980 and HCFA's 1989 home health guideline changes have essentially transformed the home health benefit from one focused on patients needing short-term care after hospitalization to one that serves chronic, long-term care patients as well. The number of beneficiaries receiving home health care more than doubled in the last few years, from 1.7 million in 1989 to about 3.9 million in 1996. During the same period, the average number of visits to home health beneficiaries also more than doubled, from 27 to 72. In a recent report on home health,[1] we found that from 1989 to 1993, the proportion of home health users receiving more than 30 visits increased from 24 percent to 43 percent and those receiving more than 90 visits tripled, from 6 percent to 18 percent, indicating that the program is serving a larger proportion of longer-term patients. Moreover, about a third of beneficiaries receiving home health care did not have a prior hospitalization, another possible indication that chronic care is being provided.

Rapid growth in home health expenditures has been accompanied by decreased, rather than increased, funding for program safeguard activities. For example, our March 1996 report found that part A contractor funding for medical review had decreased by almost 50 percent between 1989 and 1995. As a result, while contractors had reviewed over 60 percent of home health claims in fiscal year 1987, the contractors' review target was lowered by 1995 to 3.2 percent of all claims (or even, depending on available resources, to a required minimum of 1 percent). We found that a lack of adequate controls over the home health program, such as little contractor medical review and limited physician involvement, makes it nearly impossible to know whether the beneficiary receiving home care qualifies for the benefit, needs the care being delivered, or even receives the services being billed to Medicare. Also, because of the small percentage of claims now selected for review, home health agencies that bill for noncovered services are less likely to be identified than was the case 10 years ago.

Finally, because relatively few resources are available for auditing end-of-year provider cost reports, HCFA has little ability to identify whether home health agencies are charging Medicare for costs unrelated to patient care or other unallowable costs. Because of the lack of adequate program controls, it is possible that some of the recent increase in home health costs stems from abusive practices. Recent legislation, the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), also known as the Kassebaum-Kennedy Act, has increased funding for program safeguards. However, per-claim expenditures will remain below the level in 1989, after adjusting for inflation. We project that in 2003, payment safeguard spending as authorized by Kassebaum-Kennedy will be just over one-half of the 1989 per-claim level, after adjusting for inflation.

ADMINISTRATION'S PROPOSAL FOR A HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

The goal in designing a PPS is to ensure that providers have incentives to control costs and that, at the same time, payments are adequate for efficient providers to at least recover their costs. If payments are set too high, Medicare will not save money and cost control incentives will be weak. If payments are set too low, access to and quality of care can suffer.

In designing a PPS, selection of the unit of service for payment purposes is important because the unit used has a strong effect on the incentives providers have for the quantity and quality of services they provide. Another important factor is the reliability of the cost and utilization data used to compute rates. A good choice for unit of service can be overwhelmed by bad data.

The summary of the administration's proposal for a home health PPS is very general, saying only that a PPS for an appropriate unit of service would be established in 1999 using budget neutral rates calculated after reducing expenditures by 15 percent. HCFA estimates that this reduction will result in savings of $4.7 billion over fiscal years 1999 through 2002.

The choice of the unit of service is crucial, and there is limited understanding of the need for and content of home health services to guide the choice. Choosing either a visit or an episode as the unit of service would have implications for both cost control and quality of care, depending on the response of home health agencies. For example, if the unit of service is a visit, agencies could profit by shortening the length of visits. At the same time, agencies could attempt to increase the number

[1] *Medicare: Home Health Utilization Expands While Program Controls Deteriorate* (GAO/HEHS-96-16, Mar. 27, 1996). This report includes an extensive discussion of the reasons for home health cost growth.

of visits, with the net result being higher total costs for Medicare, making the per-visit choice less attractive. If the unit of service is an episode of care over a period of time such as 30 or 100 days, agencies could gain by reducing the number of visits during that period, potentially lowering quality of care. For these reasons, HCFA needs to devise methods to ensure that whatever unit of service is chosen will not lead to increased costs or lower quality of care. If an episode of care is chosen as the unit of service, HCFA would need a method to ensure that beneficiaries receive adequate services and that any reduction in services that can be accounted for by past overprovision of care does not result in windfall profits for agencies. In addition, HCFA would need to be vigilant to ensure that patients meet coverage requirements, because agencies would be rewarded for increasing their caseloads. HCFA is currently testing various PPS methods and patient classification systems for possible use with home health care, and the results of these efforts may shed light on the unit-of-service question.

We are concerned about the quality of HCFA's home health care cost report database for PPS rate-setting purposes. Our work and that of the Department of Health and Human Services' Inspector General has found examples of questionable costs in home health agency cost reports. For example, we reported in August 1995 on a number of problems with contractor payments for medical supplies such as surgical dressings, which indicate that excessive costs are being included and not removed from home health agency cost reports.[2] Also, the Inspector General found substantial amounts of unallowable costs in the cost reports of a large home health agency chain, which was convicted of fraud on the basis of these findings. We believe that it would be prudent for HCFA to audit thoroughly a projectable sample of home health agency cost reports. The results could then be used to adjust HCFA's database to help ensure that unallowable costs are not included in the base for setting prospective rates.

We are also concerned about the appropriateness of using current Medicare data on visit rates to determine payments under a PPS for episodes of care. As we reported in March 1996, controls over the use of home health care are virtually nonexistent. Our report included a number of examples of noncovered services that are billed to Medicare. For example, a physician called a claims processing contractor to complain that some of his patients were being told by a home health agency that they were homebound merely because they did not own a car. In another report, we found that some home health agency staff were directed to alter or falsify medical records to ensure continued or prolonged visits, including recording visits that were never made or noting that patients were homebound even after they were no longer confined to their homes.[3] Also, Operation Restore Trust, a joint effort by federal and several state agencies to identify fraud and abuse in Medicare and Medicaid, found very high rates of noncompliance with Medicare's coverage conditions. For example, in a sample of 740 patients drawn from 43 home health agencies in Texas and 31 in Louisiana that were selected because of potential problems, some or all of the services received by 39 percent of beneficiaries were denied. About 70 percent of the denials were because the beneficiary did not meet the homebound definition. Although these are results from agencies suspected of having problems, they illustrate that substantial amounts of noncovered care are likely to be reflected in HCFA's home health care utilization data. For these reasons, it would also be prudent for HCFA to conduct thorough on-site medical reviews of a projectable sample of agencies to give it a basis to adjust utilization rates for purposes of establishing a PPS.

In conclusion, Medicare's current payment mechanisms for home health services need to be improved. As more details concerning the administration's or others' proposals become available, we would be glad to work with the Subcommittee to help sort out the potential implications of suggested revisions.

This concludes my prepared remarks, and I will be happy to answer any questions.

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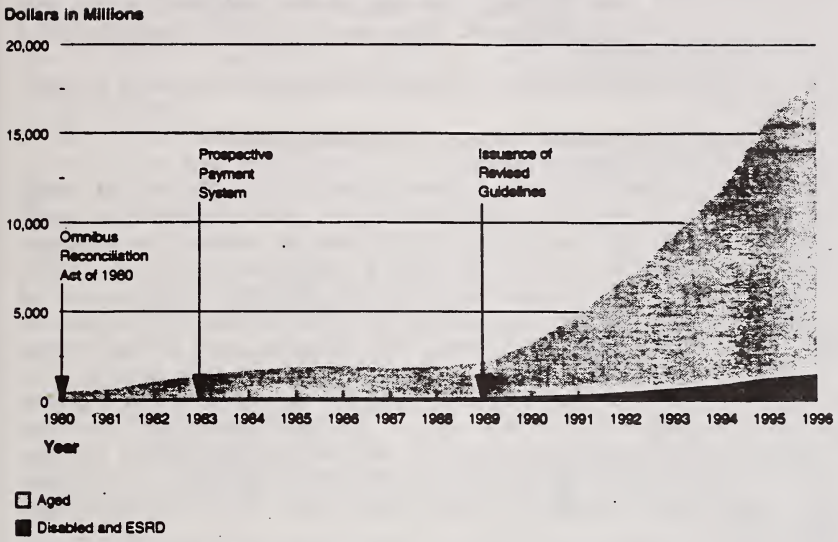
[2] *Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements* (GAO/HEHS-95-171, Aug. 8, 1995).

[3] *Medicare: Allegations Against ABC Home Health Care* (GAO/OSI-95-17, July 19, 1995).

APPENDIX I

MEDICARE HOME HEALTH EXPENDITURES, 1980-96



Note: ESRD = end-stage renal disease.
Source: HCFA's Office of the Actuary.

Mr. BURR. Thank you, Mr. Scanlon.

The Chair will recognize himself for 5 minutes.

Is it Mangano?

Mr. MANGANO Yes, it is.

Mr. BURR. Okay. Mr. Mangano, let me ask you, why the level of waste, fraud, and abuse as it relates to home health care in the private sector that much less than what we experience in Medicare, or is that a myth?

Mr. MANGANO Well, frankly, I don't know what the level is in the private sector since we really don't look at it. My guess is that it is probably going to be a fairly high level as well because in the private sector there's nobody like the Inspector General, the Department of Justice, and the General Accounting Office, and everybody else that shoulders this. I don't know that there have been studies done in the private sector which would account for that.

Mr. BURR. So only when government looks over somebody's shoulders can you be assured that waste, fraud, and abuse doesn't exist?

Mr. MANGANO Well, I think——

Mr. BURR. Do I understand you correctly?

Mr. MANGANO. The short answer is I don't know what the level is in the private sector.

Mr. BURR. Is it something you believe we ought to look at?

Mr. MANGANO I think that we can learn a lot from the private sector and as I was using in my testimony some examples of reviews that we have done which took a look at the private sector. They've instituted a number of checks on their system to keep down the over-utilization that is now existent in Medicare. Some

of the things I talked about—case managers, putting caps on numbers of services, caps on the amounts of money that is spent——

Mr. BURR. In fact, if they had the same problem we do and HCFA administering Medicare, they would be bankrupt just like we are, wouldn't they?

Mr. MANGANO Either that or the premium payers would be paying——

Mr. BURR. So they must be doing something right.

Mr. MANGANO That's correct.

Mr. BURR. Doesn't it make sense that we would look at what they do to see if, in fact, it's something we could replicate in ours?

Mr. MANGANO That's why we did do that in some of our studies.

Mr. BURR. Mr. Young, let me ask you to comment, if you will, and I'll open this to you and Mr. Scanlon, because I think both of you talked about the payment plan, be it the interim or the permanent. I'm a little concerned—and, Mr. Scanlon, you talked about the need for good data being used as we set up this plan—I'm a little concerned with the language that the administration has put in that in September, the last day of the fiscal year 1999, that as we adopt the permanent plan, that we will automatically cut the cap by 15 percent. Do we have data consistent with the decision to make that recommendation and actually put it in the language right now?

Mr. YOUNG. I think the intention of that has a budgetary scoring component with it, and the intention is that when you implement that prospective system with the right case mix adjuster, then you can certainly reduce the rates. Now the question was raised earlier, Shouldn't that be done gradually between now and that time as opposed to a sudden cliff at that point? But, the critical aspect to the reduction in the spending is to make sure that money is distributed to the beneficiaries who are the sickest and in the greatest need, and that's what the case mix measure is intended to do. If that system is not ready to be implemented when that payment cliff occurs, then you have the potential for some really serious problems.

Mr. BURR. Dr. Vladeck said that if the interim payment plan was, in fact, the permanent payment plan, we would make a mistake to cut 15 percent in September 1999. Would you agree with him?

Mr. YOUNG. Yes. I think the problem is that if the interim payment plan stays in place with the reductions, you don't have an assurance that the money is flowing to the people whose needs are the greatest, and I think that's the point he's attempting to make, and I agree with that.

Mr. BURR. Mr. Scanlon, do you have anything to add to that?

Mr. SCANLON. No, I agree. I think that one of the major issues that we face in this area is the variation that exists across the country in terms of the provisions of benefits. The interim payment plan would essentially lock those into place if it becomes the permanent payment plan. The idea of eliminating 15 percent of the expenditures also, as Dr. Young has indicated, needs to be on a targeted basis considering the degree of severity of illness of the individual patients. But we also need to understand a lot more about why patients of the same severity of illness are receiving such different levels of services in different parts of the country.

Mr. BURR. So, it would concern you if somebody stated we need to look at good data? Not necessarily do we have the data to make the recommendation of a 15 percent cut today?

Mr. SCANLON. Today, we do not have those data. We recognize that HCFA is undertaking efforts to collect some data, but it remains to be seen whether those data will be sufficient to the task in the future.

Mr. BURR. Dr. Vladeck talked several times today, and the administration has highlighted, I think, the success of Operation Restore Trust, ORT. Mr. Scanlon, in your mind is Operation Restore Trust working?

Mr. SCANLON. We think Operation Restore Trust has been effective in terms of identifying a group of agencies that appear suspect in terms of the provision of services, and then when undergoing close scrutiny, it has turned out, as Mr. Mangano has indicated, that there is a very significant prevalence of problems. There has been such an under-investment in oversight in this area that the initial returns from an investment are going to be quite considerable. We think it's worth pursuing those kinds of activities to a greater extent until we reach a point where we start to receive greatly diminishing returns from this kind of investment.

Mr. BURR. I don't know that there would be any member that would disagree with you. I would just ask if any of the three of you know how many prosecutions we have attempted to do under the Operation Restore Trust.

Mr. MANGANO Yes, I do.

Mr. BURR. What is that number?

Mr. MANGANO In the 2 years we've had about 65 criminal prosecutions, 50 civil, about 135 providers have been turned out of the Medicare program, and the recoveries and receivables that have been established to date run abut $125 million.

Mr. BURR. Can those be directly attributable to ORT?

Mr. MANGANO Those were cases that we pursued because we had the additional money that ORT provided to enable us to do the travel and investigations.

Mr. BURR. I thank you for that.

The Chair would recognize Mr. Brown for 5 minutes.

Mr. BROWN. Thank you, Mr. Chairman.

While I don't worship at the alter of the free market solving all of our problems, I do concur with Mr. Burr that we can learn some things from the private sector with dealing with fraud, waste, and abuse. I would add, however, that the administrative costs of Medicare fall somewhere in the vicinity of 2 or 3 percent. Private insurance has been four or five times that pretty much across the board, and in some plans much higher than Medicare.

Also, when you talk about administrative costs, when you talk about dealing with fraud, waste, and abuse, you can look at HMO salaries, as we have in this subcommittee from time to time. And, you can look at cases where the private sector sometimes in cutting costs have also cut services. I think you can look at some of the things that Columbia/HCA has done with non-profit hospitals. You can look at case after case. So it is not as clear-cut, perhaps, as some people would like to make us think that we should always

extol the virtues of the free market operating so much more efficiently than government agencies.

That being said, Mr. Mangano, tell us the lessons you've learned from examining the cost-controlling practices of private insurance, in HMOs for home health benefits and how these lessons will be applicable to the present situation in Medicare.

Mr. MANGANO Sure. We took a look at a number of home health agencies in the private sector, as well as other government-run programs, like the VA and CHAMPUS programs, and what we found was that they were using far more utilization control techniques—that is, tracking patients from beginning to end—from the diagnosis through the assigning of home health services, to that patient working with physicians to ensure that they got the appropriate services from organizations that they wanted to do business with, and tracking them through to completion. They were using a lot of case managers, utilization control data from the results of individual patients; they were using co-pays; they were using limits on benefits themselves. They seem to be having a more dramatic effect on reducing costs.

In the Medicare area, we tried to limit our reviews to earlier Medicare-risk HMOs which contracted out to the private sector. They were spending 25 percent as much as the fee-for-service Medicare beneficiaries on home health benefits.

Mr. BROWN. Mr. Young, thank you for being with us again this week.

In your testimony, you recommended that Medicare move to a prospective payment system where payments would cover all visits during a pre-defined episode of care. This payment method has encouraged providers to reduce the number of visits in a period to save on costs. In your experience, working with prospective payments to hospitals, do you think there will be a negative impact on the quality of care by basing payment by episode rather than by visit?

Mr. YOUNG. Our experience with the Medicare prospective payment system for hospital services did not show that there was a deterioration of the quality of care. There are differences, though, in the way that hospitals operate and home health agencies operate, and so you have to be vigilant and be concerned. On the other hand, if you look at the number of visits in 1996, and let's just arbitrarily reduce them by 20 percent, so that there are 20 percent less visits and you targeted that reduction appropriately, you'd be providing the number of visits that we provided in 1994. That's how fast the number of visits have been growing. So, there is certainly room, if you measure case mix appropriately, to reduce the overall number of visits that are being furnished, and you will still not lower those visits per person served to any substantial amount compared to those given in the 1980's. But, you need oversight mechanisms for the overall quality of care of those visits and you need to know that those visits are actually being provided by people who are capable of providing them.

Mr. BROWN. What methods might home health agencies use to skirt payment caps? What kinds of things might they do?

Mr. YOUNG. Under a prospective system?

Mr. BROWN. Yes.

Mr. YOUNG. The major problem is the balloon. Medicare is a balloon. We took the hospital part of the balloon and we squeezed down, and we've saved money over what we would have on the hospital side, and the skilled nursing and the home health side of the balloon bounced up.

Mr. BROWN. Was there just as much air in the home health part of the balloon.

Mr. YOUNG. Yes. There's always that error as long as you are squeezing on one provider and not on the whole balloon. Now, the problem you have with home health is the incentives under any prospective system; the incentive is to bring in more low-cost, low-care users, so that they can average their costs down. That's one incentive.

The second incentive that we have seen across post-acute care is that you decrease the hospital stay; you use more skilled nursing, more home health immediately afterwards. You tighten SNF, or skilled nursing facility; you use more home health.

The big problem we have to be concerned about, and within your jurisdiction, is that we have all of Part B rehabilitation services out there. If you squeeze home health, skilled nursing facility, rehabilitation hospitals, you're going to start seeing the growth in Part B services as well, and those also have to be drawn in. Now, they're not insolvable problems, but they are problems that have to be addressed.

Mr. BROWN. Thank you.

Mr. WHITFIELD [presiding]. Mr. Coburn?

Mr. COBURN. Thank you.

First of all, Mr. Mangano, I want you to know that there is another Michael Mangano, and I delivered him at about 7:30 Saturday morning in Oklahoma.

You have a namesake in Oklahoma.

You know, your testimony that between 19 and 64 percent of the claims that were audited were either for inappropriate claims or filed incorrectly—I guess I'm reading that right—or for services that weren't provided, and so I'm going to be generous, and let's just say it's 19 percent. When you apply that to the dollars that are spent on Medicare home health today, what's the dollar?

Mr. MANGANO Well, the last year the benefit was $16.9 billion. So if we take 20 percent of it, that's a considerable amount of money.

Mr. COBURN. So it's $3.2, $3.4 billion.

Mr. MANGANO Yes.

Mr. COBURN. I want to go back to the question again: you all, when you looked at this, the disparity and the number of visits, did you see any degradation or difference in the quality of care, based on the same diagnostic criteria as compared to those who had a large number? Did you see a decline in care?

Mr. MANGANO Let me answer that in this way: we did not do an outcomes-based study here in terms of looking at the quality of care that individual beneficiaries had. We did look at some surrogate measures for that, like complaints from the beneficiaries to the program, et cetera. We couldn't find any.

If I could just add one other addendum to this which I think gets at some of the answer. I was noticing Mr. Young's chart which

talked about skilled nursing care and home health aides. Those home health agencies that had the lowest numbers of visits tended to have more of those visits by skilled nurses; those who had the highest were doing the visits through the home health aides, which would tell me that there was a lower level of service being delivered by the higher-end folks than the lower-end.

Mr. COBURN. Okay. You also said there was some discrepancy in not-for-profit versus profit. Would you clarify all that?

Mr. MANGANO Sure. The profit organizations that tended to be unaffiliated were at the higher end of the scale, that is, delivering more services than the folks——

Mr. COBURN. And not-for-profit?

Mr. MANGANO The profit ones were at the higher end. The not-for-profits were at the lower end of the scale.

Mr. COBURN. Did you hear Mr. Vladeck's testimony that he was very concerned about the vertical integration and hospital SNF, and then home health care, and that one of their planned ways to handle that is to reduce the payments for a hospital? If, in fact, they had somebody hospitalized, and then discharged them to home health care, that they would—if the hospital owned it, they would pay them less than they would as if an independent contractor provided the same service was providing it.

Mr. MANGANO I did hear him say that. I just don't know enough about the details of what his plans are. Those home health agencies that we have looked at, in general, that were affiliated with hospitals and other health care organizations tended to be ones that had lower levels of utilization.

Mr. COBURN. In other words—and this is my point—my observation where I live and practice is the home health care entities that are owned or out of the hospitals are more appropriate in the services, less abusive of the services, and follow the guidelines of Medicare closer than those that are not. Can you confirm that?

Mr. MANGANO Our experience has been that as well.

Mr. COBURN. So that would seem to not go along with what Mr. Vladeck had said in terms of what their proposal is, that you have an institution that's doing it right, and now all of a sudden we're going to pay them less because they're doing it right? Anybody else have a concern about this?

Mr. YOUNG. In part, his concern relates to some work that we've done also. We've looked at changes in lengths of stay for these patients who are admitted before receiving care.

Mr. COBURN. And, again, that is a very small percentage of the number of people who are getting home health care today in this country.

Mr. YOUNG. Yes, and his comments as I heard them, and the policies proposed, focus on the payments to skilled nursing facilities as an area much more than they do for home health.

Mr. COBURN. Yes, I understand that.

Mr. YOUNG. But the position that the Prospective Payment Assessment Commission has taken is that this dramatic decline in hospital lengths of stay needs to be factored into hospital payments. And, we, as you may have read—it's received a lot of publicity—have recommended a zero update for hospitals. That is to account for these changes in practice that are occurring, and the sav-

ings that are occurring to hospitals the Commission believes should be shared with the Medicare program.

Mr. COBURN. And, I agree with you. I think it's been milked by using the SNF units, you know, get them out of here and get paid again for the same thing, and I would concur that that's inappropriate. I'm just worried that we need to look at this in a very broad sense.

Let me just follow up on one other thing. First of all, I'm very disappointed that HCFA has not implemented the physician responsibility portion that we passed last year and mandated be implemented. I think it's already having an effect in Oklahoma, as I talk to physician groups. No. 2 is that you all are recommending—or at least you are, Mr. Mangano—that they have an exam prior to the onset of care through home health, and that's not—would you recommend that for patients that are being discharged from the hospital as well?

Mr. MANGANO Well, but those patients that are discharged from a hospital would have a physician that is discharging them that would have seen them.

Mr. COBURN. And, a revisit to a physician yearly?

Mr. MANGANO Every 6 months.

Mr. COBURN. Every 6 months to recertify that they, in fact—none of you specifically qualified your statement, and if I could just finish this one point: the changes that are necessary in the Guidelines For Care, to be eligible for home health—none of you have given specifics. They've talked about less than five times out of the house in a month and 12 hours—they're working on proposals for that. Do you have any recommendations to this committee on what ought to be the proposals for the criteria for a definition of homebound that would help us as we deal on this issue? It's a very difficult issue.

Mr. YOUNG. There are certainly a number of options that you could consider, many of which were in policies that were overturned by the Duggen challenge, and I'd be happy to work with you and your staff on that. I must say, though, that the larger aspect is changes in those definitions—in home homebound, in skilled, in intermittent, and in part time—will have a substantial effect over who gets services and who does not, and that the ultimate choice of that is one that, in my mind, clearly resides with the Congress, if you wish to implement those changes. You should be well-informed to do it, but it is not an inconsequential decision you'll be making regarding the total package of Medicare benefits.

Mr. COBURN. Given the assumption that everybody that's receiving home care today is truly deserving of us spending that Medicare dollar for the service, in lieu of somebody else not getting some services that they are not going to get, because we are working with a finite budget——

Mr. YOUNG. Yes, sir.

Mr. COBURN. Thank you.

Mr. GANSKE [presiding]. Ms. DeGette?

Ms. DEGETTE. Thank you, Mr. Chairman.

I guess I have two questions. My first one is for Mr. Mangano. I was interested to hear you talk about a large reason for the fraud we've got going on is you've got physicians who are certifying treat-

ment plans for patients they've never seen. How does that happen and what can we do to eliminate—I suppose we could pass legislation saying that physicians have to see the patient every 6 months, but how is that happening in our system right now?

Mr. MANGANO Well, we've seen in some of the audits that we've done that occurring in a number of cases. A home health agency will contact either the patient's normal physician and say that they have seen this beneficiary; the beneficiary needs a particular kind of service at home, and will actually pressure a physician into signing a plan of care. We've also seen instances where the home health agencies themselves have arrangements with other physicians, which you go see this physician, and that physician will certify that you need these services, and then come back to us. Now, I want to be clear, though, that the home health agency cannot directly employ a physician that does do that. So, these are abusive situations.

Ms. DEGETTE. All right. My other question is for Mr. Scanlon, and I know we've talked a little bit before about the fraud issues. I guess my question is, in order to enforce the laws and in order to target enforcement and eliminate fraud, there's a couple different ways we can go. One of them is, for example, to tighten up the physician requirement. Another would be to target extra Federal money toward enforcement. And I guess my question to you is, if we did appropriate extra money for enforcement, would that have a cost-effective benefit to reducing instances of fraud? Or, is this something that is just endemic in the system that we really need to change the structure of the system?

Mr. SCANLON. Well, I think we need to do both. In terms of the investment of additional resources in oversight, every study that's been done has indicated that oversight has been cost-effective in identifying fraudulent and abusive claims and pays back more than the cost of resources in terms of saved program dollars. In this area, given the very minimal investment that we're making now, we certainly can expect substantial returns if we make this investment. We also need to realize that we not only target the Federal dollars to the area, but we need to be wise about targeting the dollars specifically toward agencies that we expect, or we suspect, are submitting fraudulent or abusive claims. We don't want to make this an effort that burdens everyone, because that's the kind of effort that does not turn out to be cost-effective; it is when we target our efforts that we are most successful.

But, at the same time, I think we do need to think about the system that we have in place now. We have a benefit that is being paid on a fee-for-service basis; there is no incentive for anyone to think about the efficiency in terms of use, to think about the tradeoffs that exist between the care that is being funded by Medicare, the care that might be funded by some other source, and the care that's being provided by the family.

The people that are receiving home health are often very dependent, very ill, in need of a lot of services, but it was never, it appears, Congress' intent that Medicare become the primary payer for the long-term care services that they need, and that seems to be what's happening today—long-term care for a segment of the home

health care population. Not for everyone, but just for a segment that happens to quality for the home health benefit.

Ms. DEGETTE. Thank you. I'll use that.

Mr. GANSKE. Gentlemen, I want to thank you. I think we're coming down to the last questions, which are mine.

I want to summarize what I see as this panel's testimony and to combine some of your recommendations. Mr. Mangano and Dr. Young, I think you have both testified that a prospective payment system is something that should be considered. You also both testified—correct me if I'm wrong—that some type of copayment would be useful in this area. Is that correct, Mr. Mangano?

Mr. MANGANO Yes, I offered a number of options that you should consider as you go through this process of trying to fix the program. We think that a copayment is a useful recommendation because it tends to put the beneficiary in a position of taking a look at the utilization of those services as well, and there are mechanisms to help the beneficiary to pay for that through Medigap and Medicaid itself.

Mr. GANSKE. Dr. Young?

Mr. YOUNG. Yes, sir, you're accurate.

Mr. GANSKE. Mr. Scanlon, as a representative for the GAO, would you agree with Mr. Mangano that if a patient has a co-pay, even if it's just a small one, they are more likely to look at the bill and bring to people's attention billing errors?

Mr. SCANLON. A co-pay in the past would have certainly brought the bill to the beneficiary's attention since the beneficiary was not receiving a bill before. That's been corrected and the beneficiaries are now supposed to receive notice of all services, which we think is a positive thing. Certainly having to pay some portion of the cost is going to make it even more a focus of every beneficiary.

However, I think that it's important to note, that other payers are going to cover the co-pays in terms of Medicaid and Medigap policies, and that individuals needing extensive, long-term care already pay a significant amount out of pocket. The last data that we have are from a number of years ago, but they showed people with severe disabilities that were receiving paid services were sometimes paying as much as $400 a month out of pocket. They may very much be very happy to have their dollars matched by Medicare dollars.

Mr. GANSKE. Would you agree that if, for instance, a Medigap insurer were looking over those home health care costs, that you would be adding an additional party that would be examining the validity of those services?

Mr. SCANLON. I'm not aware of Medigap insurers actually reviewing the appropriateness of claims. They've tended to defer to Medicare, and when Medicare has paid the claim, they're willing to pay their co-insurance amount.

Mr. GANSKE. Let me just follow up on this with Mr. Mangano and Dr. Young. Dr. Vladeck had some concerns about whether a copay would unduly burden those who are needy. As I pointed out earlier, co-pays are in other parts of the Medicare system, and we do take into account the effect on the poor. Do you think there are ways we could devise a copayment so that those who are truly needy, but very poor, get the services?

Mr. YOUNG. The Commission went through just that discussion and there was a lot of concern about that group. First of all, almost 90 percent of the services now furnished to Medicare beneficiaries, the deductible and copayments are picked up by a third party—Medicaid, supplemental insurance, or retirement plans. But Mr. Vladeck was also correct in that 10 percent are people who are needy. The Commission's view was that, first, the copayment should certainly be modest. There should be a limit on them, so that you are not adding co-pays to the people who are the sickest for the longest periods of time. The commission was aware of the problems, but they did not dissuade them from the recommendation anyway.

Mr. GANSKE. Okay, I want to go to a different topic that I think that probably everyone on this panel is in agreement on. Mr. Mangano, you basically said that you thought we needed more case management, and, Mr. Scanlon, you testified just now that we basically needed an audit of the entire system. I would agree with you, and I hope as we craft this legislation we provide the resources for the additional oversight that's necessary, because this is an area that is, just for the reasons, Mr. Mangano mentioned, that is just rife with abuse.

This is not just true for those who are receiving care in the home. I agree with you, Dr. Young; I saw it frequently in the hospital, when I was working, with the push to move patients out of the DRG and into the SNF unit, and it is more than a small item, I will guarantee you. And, as you say, were pushing the balloon in one spot and it goes out in the other, and we really do need to address this issue.

That's all I have and I want to thank you gentlemen for being with us today.

And, the hearing is over. Oh, we have another panel.

Excuse me. I'm sorry. Well, my apologies, we have another panel here, two more witnesses: Ms. Margaret Cushman of VNA Health Care and Mr. James Pyles of Powers, Pyles, Sutter and Verville. Ms. Cushman.

STATEMENTS OF MARGARET J. CUSHMAN, PRESIDENT, VNA HEALTH CARE, INC.; AND JAMES C. PYLES, POWERS, PYLES, SUTTER, AND VERVILLE

Ms. CUSHMAN. Thank you, Mr. Chairman. My name is Margaret Cushman and I am president of VNA Health Care in Connecticut. I chair the government affairs committee for the National Association for Home Care and also serve on its Prospect Payment Task Force. We thank the members of the committee for the opportunity to discuss with you reforms in the Medicare home health benefit and prospective payment for home care, as well as to address some concerns with the President's budget and his proposals.

First, let me address, very quickly, the factors affecting growth in the home care, which you heard a great deal about today. Despite the growth cited in home care, the total Medicare benefit now only equals about 9 percent of the total Medicare budget, and it is still a relatively small portion of total Medicare spending. It's expected—the growth is expected to moderate as well over the next several years. HCFA's actuary expects annual growth rate in the

volume of visits to steadily decreased to around 6 percent a year through the year 2000, without any of the current proposed changes.

Factors contributing to that underlying growth you've heard a great deal about. They include the aging population, technological advances, and the current preferences for home care, as well as the reduced length of hospital stays.

I would also like to point out that my written testimony covers extensively our National Association for Home Care's suggestions and stand on fraud and abuse in the home care industry.

Now, I'd like to move to prospective payment. Congress right now has a unique opportunity to improve the Medicare home care benefit in a way that home care supports and the entire industries prepared to stand behind. The home care's unified prospective payment system, introduced last year by Representative Nancy Johnson, incorporates the best elements of the proposal in last year's Balanced Budget Act, as well as in H.R. 2530.

Our goal as a unified industry was to craft a plan that would accommodate deficit reduction requirements, substitute for home care co-pays and bundling, and address HCFA's concerns about implementation. Let me be very direct about the context in which we offer this proposal.

In 1995, when we argued against copayment and bundling proposals, Congress challenged home care to develop a more acceptable way of achieving required savings. This prospective payment proposal was developed as that alternative, and it is of that we offer it today. Prospective payment is a vast improvement over the current cost-based reimbursement, which is complex and costly to administer and offers no incentives for provider efficiency. Prospective payment gives providers incentives to reduce both visit and total case costs.

Our plan entails a three-phase approach which would start with a payment very much like that proposed last year by the H.R.—I can't find the numbers again, but it is in my testimony.

Mr. BURR. 4229.

Ms. CUSHMAN. 4229. Thank you.

What the first phase would offer is a system with an annual episodic cap based upon the current cost reporting data available through HCFA with a per-visit payment limit, moving to an interim system with an episodic, a modified episodic adjustor and a case mix adjustor, and moving, ultimately, to a full episodic system.

Current Federal law and State practice acts, I would hasten to add, would provide incentives and methodologies to prevent an appropriate substitution of non-professional care for professional services. We are, however, deeply concerned about CBO's last year's scoring of a 66⅔ percent offset of prospective payment plan, and would note that that dramatically reduces the plan savings, and were similar scoring to be done again, it would be virtually impossible to offer a prospective payment plan that would be a reasonable plan and would not harm beneficiaries.

We have several concerns with the President's budget. By the design, we believe that the prospective payment system is far superior in terms of providing the necessary savings to home care, and

we feel that the President's budget provides some very disproportionate cuts to home care and would provide very difficult ways of providing the existing care, especially with the proposals to reduce or change the skilled care requirement, the intermittent requirement, and homebound requirements.

We also are concerned about the proposal to transfer from A to Part B, and would note that this would almost definitely increase the copayment required by—or, excuse me—the payment required by beneficiaries or reduce home care massively in the future periods.

While NAP endorses the prospective payment system as a fundamental improvement, as the President proposed to the current cost-based reimbursement, the administration's proposal has several serious flaws. It would essentially continue the present cost-based reimbursement with no incentives for providers to reduce cost and to increase efficiency. It would propose the Secretary devise a new PPS plan without congressional oversight or industry input, or consumer group input, and it would reduce home care costs limits and beneficiary limits by 15 percent prior to implementation, as noted before. We have several other concerns that are detailed in my written testimony, and I would be happy to answer questions.

[The prepared statement of Margaret J. Cushman follows:]

PREPARED STATEMENT OF MARGARET J. CUSHMAN, PRESIDENT, VNA HEALTH CARE, INC., ON BEHALF OF NATIONAL ASSOCIATION FOR HOME CARE

Mr. Chairman, thank you for the opportunity to present testimony today on issues related to the Medicare home care benefit. My name is Margaret J. Cushman. I am the President of VNA Health Care in Hartford-Waterbury, Connecticut. I also chair the Government Affairs Committee of the National Association for Home Care (NAHC), as well as serve on the NAHC Prospective Payment System (PPS) Task Force.

The National Association for Home Care is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's members are every type of home care agency, including nonprofit agencies, like the Visiting Nurse Associations, for-profit chains, hospital-based agencies and freestanding agencies.

The National Association for Home Care thanks you, Mr. Chairman, and Members of the Committee, for the support you have expressed for PPS for home care, as well as your leadership in helping to defeat proposals to bundle home care payments into other provider payments and to shift home care from Part A to Part B of Medicare.

NAHC is deeply appreciative of the support and attention PPS for home care has received from this Committee and in this Congress. We have been advocating such a system for more than a decade. Congress, too, has been pushing the Administration for development of a PPS for home care for many years. We were very pleased that proposals to implement such a system were included in the balanced budget plans offered in the last Congress by both parties, and that a PPS plan was passed by the full Congress as a part of HR2491, the Seven Year Balanced Budget Act (BBA) in lieu of copays. We also deeply appreciate the introduction of the industry's Revised Unified PPS plan, HR4229, by Representative Nancy Johnson.

I'd like to ask permission, Mr. Chairman, to have my full written statement, along with the following attachments, included in the hearing record: a detailed description of the industry's Revised Unified Plan, a chart showing the characteristics of Medicare home care patients, detailed comments on the President's FY98 budget proposal, and a copy of a letter from home health and hospice associations in all 50 states opposing transferring home care coverage from Part A to Part B of Medicare.

My testimony is organized as follows: factors affecting growth in home care, concerns about and efforts to address fraud and abuse, discussion of PPS, and discus-

sion of the President's FY98 budget proposals and other proposals that affect home care.

I. FACTORS AFFECTING GROWTH IN HOME CARE

Home care encompasses a broad spectrum of both health and social services that can be delivered to recovering, disabled or chronically ill persons in their homes. These services include the traditional core of professional nursing and home care aide services as well as physical therapy, occupational therapy, speech therapy, and medical social services.

Generally home care is appropriate whenever a person needs health care assistance that cannot be easily or effectively provided solely by a family member or friend for a short or long period of time. There are many situations and conditions for which home care services are especially appropriate. Technology advancements mean that every day more people are able to be cared for effectively and efficiently at home even if they have illnesses that, at one time, were only treatable in hospitals or institutions.

The home health benefit has been an evolving benefit for most, if not all, of its existence in the Medicare program. In Medicare's earliest years, home health expenditures amounted to only about 1% of the total. Today, approximately 9% of total Medicare payments are made for home health services. Therefore, while the benefit has increased each year, it still represents a small proportion of Medicare spending.

In 1996, nearly 4 million Americans received Medicare home health services, representing an estimated $18 billion in Medicare spending. Much of the increase over time can be attributed to one-time expansions or clarifications that were specifically designed to allow more individuals access to additional in-home services.

Home health growth, however, is expected to moderate and fall to more modest levels in the next few years. The HCFA Office of the Actuary expects annual growth in the volume of visits to steadily decrease to around 6% through the year 2000.

Reductions in Hospital Lengths of Stay—Growth in the home health benefit must not be looked at in isolation. There is a direct connection between the effect of PPS on hospitals and the growth in the home care benefit. PPS has made it in the hospitals' best interest to move patients out of hospitals as soon as possible, and to collect the full DRG payment for fewer days of care. In fact, over the last six years, lengths of stays in hospitals fell 31% in the DRGs most associated with post-acute care use. Average costs per discharge also declined about 6% during the same time period.

Despite a decade of continual reductions in the hospital lengths of stay, the Medicare hospital updates have never reflected these changes. Decreases in the hospital lengths of stay should be reflected in Medicare payments to hospitals. In the President's FY98 budget, home health and other post-acute care providers are penalized for the growth in their areas that have been fueled by hospitals. Hospital payment rates should be reduced to reflect this change, rather than hitting home care and other post-acute care providers.

Several other factors explain the growth in home health benefit not associated with quicker discharges of more acutely ill patients from hospitals.

Coverage Clarification—In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be covered. The result was a "chilling effect" in which some Medicare covered claims were diverted to Medicaid and some patients went without care. This "denials crisis" led in 1987 to a lawsuit (Duggan v. Bowen) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit led to a rewrite of the Medicare home health payment policies. Just as lack of clarity and arbitrariness had depressed growth rates in the preceding years, the policy clarifications that resulted from the court case allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25%) came in 1989 when the clarifications were announced; and an even larger increase took place (50%) in 1990, the first full year the new policies were in effect.

Cost Effectiveness—Home health has moved well beyond its traditional boundaries, making it possible for patients to prevent, reduce or eliminate altogether their need for more costly inpatient treatment. It is also important to note that while growth in home care has been experienced in the number of visits provided per patient, home care's costs have remained steady over the last decade, making home care still one of the best health care buys.

An Aging Population—The aging of the U.S. population will continue to influence future need for home health services. Older individuals are more likely to need home care and they are likely to use more home care services than younger home health patients. For example, the National Medical Expenditures Survey found that individuals over age 85 are three times more likely to use home care as the general elderly population, and their resource consumption was also significantly higher. Individuals over age 65 used an average of 65 visits whereas individuals over age 85 used an average of 75 visits.

Improved Access—Throughout much of the 1980s, the home care industry, along with the rest of health care, was experiencing a personnel shortage. Although there are still acute shortages of certain disciplines, conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 9,923 in 1996. Although access varies somewhat from state to state, for the most part enrollees who need home health care now have access to it.

Public Awareness and Preference—The past decade has seen dramatic increases in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery for health care services. For example, a 1985 survey found that only 38% of Americans knew about home care; by 1988, over 90% of the public understood home care to be an appropriate method of delivering health care, and supported its expansion to cover long-term care services as well. A 1992 poll found that the American public supports home care by a margin of nine to one over institutional care. Nearly 82% of all accredited medical schools now offer home health care training in their curricula.

Technological Advances—Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances has been the introduction of home infusion therapy and radical improvements in ventilator equipment.

Reductions in home care spending are likely to result in greater Medicare expenditures for hospital inpatient and emergency care, physician services, and nursing home care. Home health care serves as the safety net for patients who are discharged from acute and rehabilitation hospitals after shorter lengths of stay.

II. CONCERNS ABOUT AND EFFORTS TO ADDRESS FRAUD AND ABUSE

As in any area, growth brings with it the potential for unethical or illegal behavior. NAHC strongly believes it is the responsibility of all parties involved—patients, payors, and providers—to act aggressively to uncover, report, and act against fraudulent or abusive home care providers.

NAHC has taken a leadership role in combatting fraud and abuse. It has been engaged in a longstanding effort to maintain the highest degree of ethics and values in the health care industry through a combination of member education, cooperation with and assistance to enforcement agencies, and consistent support of federal legislative proposals designed to combat abuses in health care programs.

In January 1994, NAHC implemented a broad new policy governing member conduct. While America has enhanced home care as the site of choice for meeting its health care needs, the growth of the industry has unfortunately been accompanied by a few unscrupulous providers of care who seek only to profit illegally at public expense. The incidence of established fraud in home care services is low. However, even a single occurrence of fraud or abuse is not acceptable and must be eliminated.

The principles of NAHC's policy are as follows:

1. Policy on Member Self-Regulation

Where a NAHC member, agency, individual member, or an applicant for membership has been determined or is controlled by an individual who has been determined to have violated a criminal or civil law in either Federal or State Court on issues related to fraud and abuse, the NAHC Board of Directors may consider the imposition of sanctions, including the termination or rejection of NAHC membership.

2. Policy on Public Relations

NAHC shall respond proactively and reactively to any public relations crisis concerning fraud and abuse activity in home care and hospice.

3. Policy on Education of Members

Consistent with its mission and commitment to provide educational opportunities for members, and for the purposes of promoting standards of quality and ethics in the delivery of home care and hospice services, NAHC will provide education regarding issues of fraud and abuse in home care and hospice.

4. Policy on Enforcement

It is the responsibility of any NAHC staff person or any NAHC member to report to the appropriate legal authority any violation of fraud and abuse laws. No report shall be made by NAHC staff except where sufficient information has been obtained which demonstrates that there is a substantial likelihood that the law has been violated. Witnessing or having knowledge of an crime and not reporting it would constitute unethical behavior.

When government enforcement officials fail to act to address flagrant violation of the fraud and abuse law, NAHC may bring a civil enforcement action against the unscrupulous provider where authorized by a super majority of the Board of Directors.

5. Policy on Supporting Fraud and Abuse Legislation

NAHC shall actively support and/or initiate legislative and regulatory measures appropriate to prevent or combat fraud and abuse in the home care and hospice industries.

6. Policy on Request for Assistance

NAHC's assistance to member agencies under investigation for health care fraud and abuse shall be available only when it is determined that it is the best interests of the home care and hospice industry at large.

This policy is the embodiment of the NAHC efforts since its inception in 1983. Its enactment in 1994 was an affirmation of NAHC's commitment to maintain a leadership role in this troubling area. Evidence of NAHC's commitment is most evident in support of legislative efforts to control fraud. In 1993 and 1994, and continuing today, NAHC has publicly supported and worked to advance legislation which would expand existing health care fraud laws under Medicare and Medicaid to all payors in health care. This expansion would work to eliminate activities which escape scrutiny because of the lack of controls in certain states which allow for conduct with private health insurance payments that would be illegal if federal payments were involved. NAHC has also aggressively supported the creation of a private right of action under federal anti-kickback laws to supplement the limited resources of government enforcement agencies. In this same respect, NAHC has repeatedly supported increased funding for the Office of Inspector General at HHS.

Legislation is also needed to control the quality and delivery of home infusion therapy services. This $3 billion segment of the home care industry operates under virtually no regulatory controls and presents an environment for improper, but not necessarily illegal, conduct to occur. In 1994, NAHC highlighted the need for controlling legislation such as that offered by Congressman Sherrod Brown in the so-called "Sara Weber" bill.

Fraud has also existed within the Medicaid programs. The states' Medicaid anti-fraud units have proven success in attacking this area. NAHC has and continues to support the continuation of these programs.

Legislation alone cannot control fraud and abuse. Health care providers must have a comprehensive understanding of the standards of conduct that are allowable. Internal self-audit and self-enforcement must be done to minimize the risk of illegal activities. Over the past several years NAHC has provided extensive education on the issues involved in health care fraud. National workshops have been held at our regional conferences, annual meetings, and annual law symposiums. State home care associations have joined in this effort to extend this education to the greatest degree possible.

NAHC believes that increased public awareness is a valuable means of oversight and that the public must be fully involved in the process of fighting fraud. It is the health care consumer and the taxpayer who are ultimately the injured parties. While the government should increase the information it provides to the public about known schemes and scams, the health care industry must also do its part. In accordance with the NAHC fraud and abuse policy, the home care industry has not only cooperated with media investigations but has worked to engage the attention of the media to focus on important areas of concern.

One of the most important roles that the home care industry plays in eliminating fraud and abuse is to lend its knowledge and expertise to enforcement authorities. Over the years, NAHC has acted as an extension of the investigatory arm of federal and state enforcement authorities. On the simplest of levels, NAHC has put individuals and providers of services who have evidence of fraudulent conduct in touch with the HHS Office of Inspector General. On a deeper level, NAHC has provided guidance to enforcement authorities on areas in which resources might be targeted in their home care efforts.

Historically, fraud and abuse in health care has taken the form of false claims in Medicare cost reports, billings for services never rendered, and kickbacks for referrals. These types of fraud are now being replaced with an entirely different form of abuse found in managed care. While in the traditional fee-for-service system incentives exist for overutilization and overcharging. But managed care may create financial incentives to improperly underutilize care. The health care consumer is harmed doubly in these circumstances; *financially,* care is prepurchased but not delivered; and *healthwise,* necessary care is lost. NAHC strongly recommends that Congress and the enforcement authorities take a long hard look into the abuses in managed care. New strategies must be developed to address this new type of fraud. Clinicians, rather than accountants, will need to operate at the heart of this effort. Good managed care can help bring about economy and efficiency in health care. Bad managed care, controlled by financial greed, can mean the death of the patient.

Recommendations to Combat Fraud and Abuse

During the 104th Congress, NAHC played an active role in helping shape an anti-fraud health care package. Ultimately, these proposals were incorporated into the Health Insurance Portability and Accountability Act, P.L. 104-191, that was passed into law.

Passage of the anti-fraud package marks a good first step in eliminating waste fraud and abuse in our health care system. There are, however, some specific issues within home care that need to be addressed by anti-fraud legislation.

Congress should continue its work in combating waste, fraud and abuse in our nation's health care system by passing a home care specific anti-fraud package that includes:

- *Limiting Agencies' Ability to Subcontract Care.* Medicare certified home health agencies should be allowed to utilize only a limited amount of subcontracted care for the dominant health care service, such as nursing, which they provide.
- *Mandating Freedom of Choice Information.* Hospitals, physicians, and other health care providers, should be required to give patients full information about the availability of Medicare certified home health agencies serving the areas in which the patients reside, and should be prohibited from steering patients to certain agencies.
- *Prohibiting Home Health Agencies from Assisting Physicians in Care Billing.* Home health agencies should be prohibited from providing record keeping and bill preparation services to physicians for their role in home care.
- *Requiring Home Health Care Administrators to Meet Certification and Accreditation Standards.* The last several years have seen a unbridled growth in the number of Medicare certified home health agencies. Home care agency administrators should be required to meet high and rigorous standards for all aspects of running an agency, including issues that affect quality of care.

III. PPS FOR HOME CARE

Congress has before it a unique opportunity to work closely with the home care community to improve the Medicare home care benefit. The Revised Unified PPS plan offered to Congress by the home care industry and introduced by Representative Nancy Johnson (HR4229) incorporates the best elements of the home care PPS provisions in the Balanced Budget Act (BBA) passed by Congress and HR2530, the Blue Dog Coalition's budget plan introduced in the 104th Congress.

The Revised Unified PPS Plan represents the most advanced thinking that's been done in developing a PPS plan. It also represents a substantial improvement over the current Medicare cost-based reimbursement system.

Let me be very direct regarding the context in which we are offering this PPS proposal. In 1995, Congress proposed sizable savings from the Medicare program, a portion of which was to come from home care. Since the industry found copayments and bundling unacceptable, Congress challenged us to develop a more acceptable way of achieving the required savings. This PPS proposal was developed as an alternative to home care copays, bundling, and other onerous ideas, and that is the context in which we are offering it today.

Our goal was to develop a PPS plan that 1) the home care industry could support, 2) would use the best that both the Republican (BBA) and Democratic (HR2530) plans had to offer, 3) would address concerns raised about the PPS plans in both the BBA and HR2530, 4) would accommodate deficit reduction requirements, 5) would substitute for home care copays and bundling, and 6) would address HCFA's concerns about feasibility of implementation on a timely basis.

Advantages of PPS

PPS offers numerous advantages to the Medicare program over the current cost-based reimbursement methodology. Under current law, home health agencies are reimbursed for the allowable costs which they incur in caring for Medicare patients up to a per visit cap. Cost reimbursement, however, has been criticized because it is complex and costly to administer, because the amounts that are paid are subject to disallowance and recoupment long after the services have been rendered and because it offers no incentives for provider efficiency.

PPS, by providing desirable, market-like incentives that encourage the efficient and effective provision of care, would avoid these problems because payment rates would be established in advance.

PPS, by providing financial incentives for home care agencies to reduce both visit and total case costs, will achieve Medicare savings without restricting beneficiary access to high quality home care services. PPS properly places the burden to be efficient in the provision of care on providers and not beneficiaries. Alternatives to PPS, like copayments and bundling, create barriers to high quality home care services by increasing a beneficiary's out-of-pocket expenses and restricting access to post-acute care services.

Revised Unified PPS Plan

The Revised Unified PPS Plan that we are testifying in support of today is a modification of the original unified plan submitted to Congress in 1995.

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. Our goal was to develop an episodic system which would: be developed cooperatively by HHS, the industry, and Congress, be acceptable to the industry, include extended care, be submitted to Congress one year in advance of implementation, and within four years of enactment of legislation, be implemented only after Congressional approval, include adjustments for new requirements (such as OSHA) or changes in technology or care practices, be based on a case-mix adjuster that reflects the differences in cost for different types of patients, prevent the imposition of home care copays, bundling, or other benefit limits, implement a per-episode PPS as soon as possible, and do as little harm as possible to home care patients and providers in implementing an untested system.

This plan, which represents years of work and refinement by the home care industry, calls for a three-phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case-mix adjuster and would require the development, within five years, of a per-episode PPS with a case-mix adjuster that adequately distinguishes the cost of providing services to various types of patients.

Phase 1 of the Plan would implement a prospectively-set standard per-visit payment with an annual aggregate per-patient limit that applies to all visits. Phase 2 would put in place prospectively set standard per-visit payments with an annual aggregate episode limit for days 1-120 and an annual aggregate per patient limit for visits after 120 days. Phase 3 puts in place a per-episode PPS.

This PPS plan would give home care providers incentives to reduce costs and increase efficiency through a provision in which they would be allowed to keep a portion of the difference between the total per visit payments and the agency's annual aggregate cap. This provision differs from the way PPS for hospitals was implemented, in which hospitals are allowed to retain the entire difference between the DRG payment rate and the cost of care. Under the revised unified PPS proposal, home care providers would be allowed to retain 50 percent of the difference, up to a cap, with the balance of the savings used for the exceptions process.

Scoring

NAHC has been working with the accounting firm of Price Waterhouse in reviewing the potential cost savings available through this proposal. We believe it to represent savings roughly equivalent to the savings offered under the Administration's PPS proposal and have built into the proposal a number of components that can be adjusted to achieve necessary savings.

We are deeply concerned about certain assumptions the Congressional Budget Office has employed in scoring PPS proposals for home care. In assessing the prospective payment proposal included in HR2491, CBO imposed a 66⅔% offset that had the effect of dramatically reducing potential savings the proposal could have achieved. This offset reflects CBO's assumptions of behavioral changes on the part

of home health care providers in response to this proposal, as well as their assumption of the proposal's effectiveness.

CBO used this two-thirds offset to calculate net savings for the home health prospective payment provision, meaning that the sum of gross savings for each provision of the proposal was reduced by two-thirds. Under this offset, a proposal scored at $14.2 billion in savings over seven years, as was the PPS proposal in the BBA, actually would reduce Medicare home health expenditures by $42.6 billion over seven years, or three times the scored amount.

Never before, to our knowledge, has CBO employed such a dramatically high assumption of gaming. An offset of this magnitude is entirely unjustified and makes it much more difficult for home care to present a proposal offering necessary savings that does not inflict great hidden harm to home care beneficiaries.

History of PPS

NAHC has long supported the development of a prospective payment system for home care. NAHC championed the initial PPS demonstration legislation that Congress passed in 1983 as part of the Orphan Drug Act (P.L. 97-414). In that legislation, Congress required the Medicare program to test alternative reimbursement methodologies to determine the most cost effective and efficient way of providing care, including fee schedules, prospective payment, and capitation payments.

Following the passage of this legislation, the industry, through the National Association for Home Care, created its first Prospective Payment Task Force. When the demonstrations authorized under that legislation were held up in 1985 by the Office of Management and Budget, NAHC stepped in and partially funded the Georgetown University study on patient classification.

The U.S. Department of Health and Human Services (DHHS) did not undertake any serious effort to follow through with the study required in the 1983 legislation. Accordingly, the industry sought a stronger mandate from Congress.

With the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), Congress required that DHHS design a prospective payment demonstration in a manner that would enable the Secretary to evaluate the effects of various methods of prospective payments (including payments on a per visit, per case, and per episode basis) on program expenditures, as well as beneficiaries' access to care. An interim report was required by Congress within one year after enactment of the legislation. A final report was due four years after enactment. The demonstration was set to begin no later than July 1, 1988.

The Health Care Financing Administration (HCFA) was unable to move the demonstration project forward on a timely basis and sought a delay from Congress. As part of the Medicare Catastrophic Protection Act of 1988, OBRA-87 was amended to modify the effective date from July 1, 1988, to April 1, 1989.

After nearly three years with limited effort by DHHS, Congress, at the request of the home health industry, once again intervened in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). Congress directed HCFA to research and report back to Congress on whether to move cost-based providers, including home health agencies, to some form of alternative reimbursement. DHHS was required to submit a report to Congress that included a proposal for prospective payment for home health agencies by September 1, 1993. The Prospective Payment Assessment Commission was to analyze the DHHS proposal and report to Congress by March 1, 1994.

In developing this proposal, DHHS was required to: (1) provide for appropriate limits on home care expenditures; (2) account for changes in patient case-mix, severity of illness, volume of cases, and the development of new technologies and standards of medical practice; (3) consider the need to increase payment for outlier cases, those cases which exceed the average length or cost of treatment; (4) address the varying wage-related costs among agencies; and (5) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments.

Ultimately, HCFA initiated a two phase demonstration project to study prospective payment for home health services. In Phase 1, HCFA experimented with a per visit prospective payment methodology. That project, which concluded in 1994, found limited effect on the behavioral actions of home health agencies and expenditure through the use of a per visit method of reimbursement.

Phase 2 of the demonstration project was initiated in March, 1995. Phase 2 is intended to study the behavioral reaction to a per episode based prospective payment system using a case-mix adjustor that classifies patients into one of eighteen categories. As the result of the weaknesses of the case-mix adjustor, explaining only 9.7% of variation in costs for various types of patients, HCFA limited the focus of the demonstration project to analyzing behavioral changes for participant home

health agencies. It is expected that a final report will be issued on Phase 2 of the demonstration project in either 1999 or 2000.

We would like to reiterate that the industry's Revised Unified PPS Proposal, while an improvement over the current cost-based reimbursement system, is being offered solely in the context of deficit reduction as an alternative to other home care savings proposals.

Some alternatives, including shifting some home care from Medicare Part A to Part B, placing copayments on Medicare home health visits, and bundling home care payments into hospital DRGs or other provider payments, would have serious detrimental effects on the nearly 4 million Americans who rely on quality home health care. Moreover, these proposals could severely limit access to home care, limiting health care choices for our Nation's elderly and disabled to more costly institutions.

We were extremely gratified that in the BBA, the Committee abandoned home health copayments and bundling in favor of a prospective payment system (PPS) as a way to ensure the efficient delivery of home care services.

IV. PRESIDENT'S FY98 BUDGET PROPOSAL

The provisions included in the February 11, 1997 draft of the Administration's FY98 budget package would have a dramatic impact upon the delivery of home health care under Medicare. Home care would be subject to a level of cuts which is disproportionate to its share of the Medicare program. Home health comprises 9.6% of total Medicare outlays, but would sustain 13% of the cuts requested by the President. For comparison purposes, skilled nursing facility payments now comprise about 6% of total Medicare outlays, but would sustain 7% of the cuts, which is much closer to its proportion of program outlays.

Beyond the depth of the home care cuts, NAHC has grave concerns about the overall effect of the Administration's budget on the future of the Medicare home health benefit. While the President's proposal puts forth a plan to implement a prospective payment system (PPS) for home care and takes a first step toward providing much-needed respite for informal caregivers of Medicare Alzheimer's victims, draft legislative language reveals proposals that would create two separate home care benefits under Part A and Part B of Medicare, impose arbitrary limits on home care and reverse hard-won legal battles which broadened availability of home care to deserving beneficiaries. Additionally, the proposed FY98 budget would grant broad Secretarial authority to deny payment for services which lie outside "norms of care" and to lump post-acute services into a single care payment.

Despite some benefit expansions, the proposed budget translates into very real reductions in access to home care services for needy Medicare beneficiaries.

Transferring Some Home Health Coverage From Part A to Part B of Medicare

Under the President's proposal, Part A would cover home health services only when both of the following conditions are met: (1) home health services are furnished to an individual under a plan of treatment established when the individual was an inpatient of a hospital or rural primary care hospital for not less than three consecutive days before discharge, or during a covered post-hospital extended care stay, and (2) the home health services are initiated for such individual within 30 days after discharge from the hospital, rural primary care hospital, or extended care facility.

All other home health care services—including services not following a hospitalization and services beyond 100 visits—would be covered under Part B.

The additional home care costs transferred into Part B would not be used in calculating the Part B premium, which traditionally covers 25% of Part B program costs. Individuals who have Part A coverage only would continue to have all their home care services covered by Part A until 19 months after the date of enactment.

This proposal would do little to address the underlying insolvency issues facing the Part A trust fund. We are deeply concerned that this proposed shift will result in increased tax burdens on middle income families and increased costs to Medicare beneficiaries, and may deny needed home care services to millions of seniors and disabled individuals.

This shift would transfer up to $82 billion in costs directly onto taxpayers. The size of the increased burden on taxpayers resulting from this transfer would continue to rise over the years.

If Medicare beneficiaries were required to contribute to the costs of home care transferred to Part B, premiums have been estimated to increase by nearly 20 percent—$8.50 per month in 1998, rising to $11.00 per month by 2002. The Part B monthly premium is already $43.80.

This transfer may also make the home care benefit more susceptible to beneficiary copays and deductibles. As a result, Medicare home health beneficiaries could be subjected to additional coverage restrictions that would further reduce the benefit. This proposal would decrease cost-effective medical benefits to millions of Americans at a time when the need for home care services is growing.

We are additionally concerned that 2.1 million elderly and disabled Medicare beneficiaries who are covered by Part A, but not by Part B, may lose access to much of the Medicare home care benefit under the President's proposal. Beginning 19 months after enactment, the benefit for these individuals would be limited to only 100 visits and only if the care began immediately following a hospital stay of at least three days or discharge from a covered extended care facility. To the extent that these individuals are either already Medicaid eligible, or would spend down to Medicaid due to increased health care costs, this provision would result in an increased burden on State Medicaid programs.

NAHC proposes, instead, fundamentally improving the way Medicare pays for home care services by enacting a prospective payment system (PPS) for home care.

PPS For Home Care

The Administration's PPS proposal included in the FY98 budget submission falls short of the industry's expectations in a number of ways.

The interim payment proposal essentially continues the present cost-based reimbursement system, while eliminating any savings sharing that gives providers incentives to reduce costs and increase efficiency. Both the Administration's previous plan, as well as HR 2491 (the Congressionally passed plan) and HR 2530 (the Democratic alternative) contained such incentives for providers. With the retention of cost reimbursement and the elimination of the savings sharing provisions, this plan contains little by way of incentives for providers to participate in creating more efficient operations.

The interim system would also delay the implementation of blended limits for three months. Totally agency-specific limits tend to maintain previous behaviors, both good and bad. This delay would penalize the most efficient providers.

The Administration's plan also calls for the collection of data to develop a reliable case mix adjuster. While clearly necessary, this provision would result in substantial additional costs to agencies. The cost of this new data gathering requirement should be fully reflected in reimbursement rates under this system.

The Administration's PPS plan has serious flaws, as well. Under this plan, the prospective payment system is to be devised by the Secretary without Congressional oversight or participation by industry or consumer groups. The Administration would also reduce home health cost limits and per-beneficiary limits by 15%, prior to implementation of PPS. This reduction is onerous and unnecessary under PPS.

Interim Payment for Home Health Services

This provision delays updates in the Medicare cost limits from July 1, 1997, to October 1, 1997. As of October 1, 1997, the cost limits would be calculated on the basis of 105% of the median of the labor-related and nonlabor per-visit cost for free-standing home health agencies. Currently, cost limits are calculated on the basis of 112% of the mean. The standard of 105% of median is the effective equivalent of approximately 97% of the mean.

A reduction of the cost limits to 105% of the median is estimated to affect the limits by approximately $10.00 per visit for skilled services and nearly $5.00 per visit for home health aide services. This amendment combined with the disregard of two years of cost increases under the section that maintains the savings from the freeze (discussed below), would reduce the cost limits by approximately 17%.

The delay in cost limit updates could provide a benefit to providers of services having cost reporting periods beginning between July 1 and September 30. These providers would maintain the same higher level of cost limits than would be calculated under the revision for a period of two years, while providers of services with fiscal years beginning on or after October 1 would be subject to a precipitous drop in allowable reimbursement.

The savings resulting from the freeze and the interim payment system would be unnecessary if the industry's Revised Unified Plan for Prospective Payment were adopted by the Congress. While the industry's plan would reduce per-visit payment, it gives providers a more important incentive to reduce overall case costs by restraining the growth in the utilization of services per patient.

PPS would achieve reasonable payment reform and associated budget savings without dramatic reductions in the unit of payment. With the current high degree of federal regulation of home health services, it is difficult and sometimes impossible for a home health agency to initiate large cost reductions with little or no notice.

The proposed cost limit reductions ultimately carry the risk that quality of care and access to services may be jeopardized.

Maintaining Savings Resulting From Temporary Freeze on Payment Increases for Home Health Services

This provision in the President's package requires the Secretary to disregard increases in the cost of providing home health care which occurred between July 1, 1994, and July 1, 1996, in updating the home health cost limits after September 30, 1997. The purpose of this provision is to recapture the savings which the program would have incurred if the two-year freeze, which was lifted on July 1, 1996, had been continued. The proposal also limits the Secretary's authority to consider cost changes during the two year period when determining whether a home health agency is entitled to an exemption or exception from the cost limits.

This provision would significantly reduce the current Medicare cost limits. Those limits, implemented with cost report years beginning July 1, 1996, represented the first increase in the limits for home health agencies since July 1, 1993. The reduction in the cost limits through this provision would approximate $7.00 per visit or 7% of the limits. As a result, a significant percentage of home health agencies would provide services at costs above the limit, receiving less reimbursement than the cost of providing the care.

As mentioned earlier, the impact of this provision is magnified when combined with other sections in the President's budget proposal, including the section on interim payment methodology, which further reduce the cost limits for all home health agencies.

Clarification of Part-time or Intermittent Nursing Care

This amendment modifies two provisions of Medicare law which affect the eligibility of beneficiaries for home health services coverage and the level of coverage available. With respect to the test to qualify for home health services coverage, current law requires that the Medicare beneficiary demonstrate a need for skilled nursing care on an intermittent basis or physical or speech therapy.

The provision would restrict Medicare home health eligibility and coverage beyond that available under current law. The existing interpretation of "part-time or intermittent" is the result of a 1988 class action lawsuit which invalidated restrictions on daily, part-time care.

The President's proposal defines "intermittent" as skilled nursing care that is either provided or needed on fewer than seven (7) days each week or less than eight (8) hours of each day of skilled nursing and home health services combined for periods of twenty-one (21) days or less with certain exceptions. At present, there is no definition of "intermittent" contained within existing statute or regulations.

With respect to the level of coverage available for a qualified Medicare beneficiary, current law limits coverage of skilled nursing care and home health aide services to care which is "part-time or intermittent." This amendment proposes to define "part-time or intermittent" services as a combination of skilled nursing and home health aide services furnished less than eight (8) hours each day and thirty-five (35) or fewer hours per week. There is no existing statutory or regulatory definition of this term.

The proposed definition of "part-time or intermittent services" eliminates an important protection which allows for coverage beyond thirty-five (35) hours per week under exceptional circumstances when the need for the additional care is finite and predictable. This component of the definition allows for short term extended hour coverage for individuals such as those awaiting placement in a skilled nursing facility where no bed was available and those patients with a short term acute episode of care which could be reasonably provided at home, avoiding institutional placement in a hospital or nursing facility.

The proposed definition of "intermittent" used to qualify a Medicare patient for home health services also adds new restrictions. While existing law requires the patient demonstrate a need for intermittent skilled nursing care, the proposed definition of "intermittent" combines skilled nursing and other home health services in determining whether the "intermittent" skilled nursing care requirement has been met. This would exclude eligibility for some patients who currently qualify for Medicare home health services coverage.

For example, an individual that receives daily home health aide services from unpaid caregivers, such as family members, while receiving Medicare covered weekly skilled nursing care would be entirely disqualified from Medicare coverage. Even if this definition were limited to the combination of skilled nursing and other home health services provided by a home health agency, currently eligible Medicare beneficiaries would be denied coverage.

To amend the Medicare act as proposed would not result in a clarification of these terms. Instead, it would result in a reduction in benefits to Medicare beneficiaries.

Definition of Homebound

This amendment establishes new criteria for determining whether an individual's absences from the home demonstrate that the Medicare beneficiary fails to meet the "confined to home" standard. Specifically, the proposal requires that an individual demonstrate the existence of a condition that restricts the ability to leave the home for more than an average of 10 to 16 hours per calendar month for purposes other than to receive medical treatment that cannot be provided in the home.

The proposal further defines existing terms of "infrequent" to mean an average of five or fewer absences per calendar month and "short duration" to mean absences of three or fewer hours on average per absence. Current law allows for nonmedical absences which are infrequent or of short duration. Medically related absences for treatment that cannot be furnished in the home do not affect an individual's homebound status.

This proposal would add to the confusion surrounding application of the homebound criteria. Under the proposal, several plausible interpretations may be possible. For example, while the existing law allows for absences which are either infrequent or of short duration, the proposal referencing absences averaging 10 to 16 hours per month may be interpreted to combine these two limitations. At the same time, the 10 to 16 hour reference may be interpreted in a manner which indicates that the restrictions for leaving the home begin only after that number of hours since the word "restricts" is not the equivalent of "prevents."

Home care agencies and patients are likely to have great difficulty in dealing with the allowance for medical absences in demonstrating that the treatment "cannot be furnished in the home." Currently, for example, most medically related treatments can be provided in the home. A home visit by a treating physician can often adequately meet a patients needs. However, physician services are not generally accessible in the home.

Many current Medicare beneficiaries, especially disabled patients, may be disqualified from Medicare home health services coverage under this provision. In addition, rather than adding clarity to a confusing area, it only adds to the difficulty in interpretation and application through the addition of new terms subject to dispute.

Individuals that attend adult day care, at no expense to the Medicare program, through the use of specialized transportation should not be disqualified because absences are more frequent than five per calendar month or three hours per absence. These individuals generally cannot receive the necessary health care services outside the home and are truly homebound in the absence in the specialized transportation. Likewise, disabled individuals who are bedbound without the assistance of home health staff should not be disqualified where specialized equipment allow these individuals to leave the home for education, employment, or other purposes. Disqualifying these individuals due to their absences eliminates the availability of essential services which create the opportunity for absences. Many disabled individuals are bedbound unless home health services are provided.

Normative Standards for Home Health Claims Denials

This provision provides authority to the Secretary to deny the frequency and duration of home health services where that care is "in excess of such normative guidelines as the Secretary shall by regulation establish." This provision allows the Medicare program to utilize norms of care for eliminating coverage to individuals.

The Medicare program's practice of using norms of care was outlawed under a settlement agreement in the national class action *Duggan* v. *Bowen* in 1989. Under that settlement, the Medicare program is required to render *individualized* claim determinations which respect a particular Medicare beneficiary's illness, condition, and need for treatment. At that time, it was recognized by the Medicare program that the determination as to the level of care which was reasonable and necessary could only be rendered through an individualized review of that patient's circumstances.

This provision should be rejected. The federal government should not attempt to micro manage how much and what types of home care services each patient can receive. PPS for home care would provide prudent payment levels while allowing home health care providers (could) to determine how best and most efficiently to meet patients' needs. A similar approach is used with Medicare hospital services under which a flat payment is made to a facility based upon a patient's diagnosis regardless of whether the patient receives care less than or in excess of the norms.

The hospital payment provision, however, provides for an outlier payment to recognize that certain patients reasonably require care beyond normative standards.

Further, the Secretary cannot reasonably and accurately establish normative guidelines for home care. Currently, the Medicare program is developing a case mix adjuster for use in a future PPS. However, that case mix adjuster, while categorizing patients, is expected to allow for flexibility in the provision of services to patients within the respective categories.

The use of norms implies an average amount of care for patients within set criteria. Averages cannot be used to deny coverage to individuals since the averages are made up of a range of care needs of specific patients. This proposal will guarantee that many individuals who need home health services would be denied Medicare coverage.

The implementation of this provision will also lead to an endless series of disputes, including litigation, as to the accuracy and objectivity of the calculated norm of care for the particular category of patient. In the end, this provision will be costly to administer, creating harm to Medicare beneficiaries, leading to increased health care costs for underserved patients, and restricting coverage to individuals currently entitled under Medicare law.

Development and Implementation of Integrated Payment System for Post Acute Services

This provision authorizes the Secretary to establish an integrated payment system for post acute services furnished by skilled nursing facilities, home health agencies, rehabilitation hospitals, long term care hospitals or such other entities as the Secretary deems appropriate. The payment system may include a single prospective pay rate for all services or a limit on the amounts payable to individual providers or to a single entity.

In establishing the payment system, the Secretary must consider equitable payments across provider types, case mix adjustments, geographic variation, and outlier payments. The Secretary must establish the system to be budget neutral. The system must include quality assurance and monitor. Finally, the Secretary is authorized to require providers of services to supply the necessary data and other information necessary for implementation, including the development of a standardized core patient assessment instrument.

The authority of the Secretary to implement an integrated payment system for post acute services does not apply to payments for services furnished before 2002.

NAHC opposes combining, or bundling, home care payments with payments to other providers. Congress should, instead, enact separate prospective payment systems for home care and other post-acute care providers.

Congress should also rebase the hospital DRGs to reflect shorter lengths of stay that have occurred under the hospital PPS.

Nearly half (41%) of all home care patients are now able to receive care and treatment at home from the onset of their illness, avoiding hospitalizations altogether. According to the Prospective Payment Assessment Commission's (ProPAC) June 1996 report to Congress, patients in other post-acute settings were usually discharged from acute care hospitals, but only 59% of all home health episodes were preceded by a Medicare-covered hospital stay.

Bundling would vastly increase Medicare's administrative complexity and the cost of providing home care services by requiring multiple payment systems for home care—one for post-acute patients and one for other home care patients.

User Fees

The Administration would allow States to impose user fees on providers for initial surveys needed for participation in the Medicare program. NAHC opposes user fees and recommends that Congress ensure sufficient funds to cover the costs for survey and certification activities without imposing additional fees on providers.

For the past several years, HCFA's funding for survey and certification activities has been insufficient to complete the level of reviews mandated by Congress. As a result, many state survey agencies were unable to conduct initial surveys of new providers in a timely manner. Providers in these states, therefore, are experiencing long delays in receiving Medicare certification.

The fiscal year 1996 budget (P.L. 104-134) contained a provision designed to provide HCFA the budget flexibility to begin to alleviate the backlog of initial certifications. The legislation increased the time between home health recertifications from once every 12 months to once every 36 months and expanded HCFA's authority to deem agencies as certified if the agencies are accredited by certain private accrediting bodies. In addition, Congress appropriated an additional $10 million over FY96 levels for survey and certification activities in FY97.

Despite these legislative efforts, backlogs for initial surveys in some states still exist. The Administration's proposal would allow states to impose user fees on providers who wish to pay for their initial surveys. In addition, the President's budget reduces the direct appropriation request for survey and certification by $10 million. The Administration estimates that this $10 million reduction will be made up from user fees, thereby keeping the funding for survey and certification activities at FY97 levels.

User fees are a tax on new providers for participating in the Medicare program. Asking health care providers to provide quality care while at the same time asking them to shoulder both government costs and their own expenses related to the Medicare program is unfair. Moreover, while the proposal imposes user fees only on initial surveys, some existing providers may also be subject to this "tax." For example, home health agencies who wish to open a hospice would be subject to the fee for the hospice's initial survey. In addition, HCFA's recent reclassification of some home health branch offices as subunits would also require initial surveys be conducted for those reclassified facilities.

Fraud and Abuse

The President's budget proposal calls for the repeal of advisory opinions, the exception to anti-kickback penalties for risk-sharing arrangements; and the clarification concerning levels of knowledge required for imposition of civil monetary penalties.

NAHC opposes repeal of these important provider guidance provisions contained in the Health Insurance Portability and Accountability Act (P.L. 104-191).

The Health Insurance Portability and Affordability Act of 1996 put in place a broad based anti-fraud package that balances increased enforcement tools with opportunities for provider guidance. The fraud and abuse legislation established a criminal health fraud statute and increased civil monetary penalties. At the same time, the legislation clarified existing law, created a safe harbor exception for certain risk-sharing arrangements and allowed providers to request advisory opinions from the Department of Health and Human Services (HHS).

The health insurance reform law reflected an effort to balance increased enforcement tools with greater opportunities for guidance and clarification of areas that have previously led to confusion and unintended consequences for providers. Provisions such as the establishment of advisory opinions will assist home care and hospice providers in ensuring that they remain in compliance with health care statutes and regulations. Without these provisions, new criminal sanctions and increased civil monetary penalties may be imposed on home health and hospice providers without adequate opportunities for guidance or clarification of existing law.

Site of Service

The intent of this section in the President's proposal is to ensure that Medicare payments for home care more closely reflect the costs of care in the place where the care is given, the patient's home, rather than the site of the home health agency office.

This section would address this issue in two ways: It may require home health agencies to submit each claim to the fiscal intermediary (FI) that covers the patient's home, rather than submitting all claims to the FI that covers the agency office location, or to require information on the patient's location to be included in the claim. It may also require that the labor costs associated with the area in which each patient receives home care, rather than the agency office, be used in calculating Medicare payment limits for home care services.

NAHC supports this section, with two significant changes.

First, the section should be rewritten to clarify its intent and to amend Section 1815, rather than Section 1891, of the Social Security Act.

Section 1891 of the Social Security Act sets out requirements to assure home health quality, such as patient rights, training and competency testing of home health aides, and quality surveys and sanctions for home health agencies found to be out of compliance with the quality measures of Section 1891.

The President's proposal would require quality surveyors to begin examining claims forms to find that they match with the correct FI for each patient's area. Quality surveyors are already sorely overworked and underfunded. This non-quality specific requirement would detract from their ability to devote their efforts to ensuring high quality standards in all home health agencies.

This section should be moved to Section 1815 of the Social Security Act, which sets out requirements that providers must meet in order to receive payments under the Medicare program.

Second, home care payments should reflect the labor costs for activities performed both in the patient's location and in the home office area. The Administration's proposal would only recognize the varying labor costs that occur specific to the site of care. Billings, clerk functions, and other activities that are carried out in the agency office should reflect the costs of labor in the office location.

Respite

The President's budget proposal would establish a new respite benefit for the families of Medicare beneficiaries with Alzheimer's disease or other irreversible dementias, beginning in FY98. The benefit would cover up to 32 hours of care per year and would be administered through home health agencies or other entities, as determined by the Secretary of HHS.

Payments would be made at a rate of $7.50 per hour for 1998 and at a rate to be determined by the Secretary in subsequent years. Total payment to the agency or organization furnishing respite services could not exceed 110 percent of the hourly respite allowance times the number of hours of respite for which the agency authorizes payment.

Beneficiaries eligible for this benefit must be severely impaired due to irreversible dementia and need assistance in at least one of five activities of daily living (bathing, dressing, transferring, toileting and eating) or in at least one out of four instrumental activities of daily living (meal preparation, medication management, money management, and telephoning), or needs constant supervision because of a behavioral problem.

Families would be allowed to designate a respite services caregiver through a home health agency or other organization designated by the Secretary. The patient could not be charged more than $2.00 in excess of the the hourly rates established by the legislation.

Respite aides may be nurse aides, home health aides, or other individuals licensed by the State or recognized by the Secretary as having the skills necessary to provide such services.

NAHC is pleased that the Administration has proposed a modest beginning in addressing this unmet need. Nearly three-quarters of non-institutionalized disabled elderly persons rely solely on care by friends and family; only 5% receive all of their care from paid sources.

While the respite provision is a step in the right direction, it provides for too few hours and the rates of reimbursement are inadequately low. Payment rates should reflect variation in costs by geographic region and should be adequate to both attract qualified respite aides and pay for their training and supervision. The legislation should also mandate that the Secretary develop competency standards for respite aides.

The availability of respite care can mean the difference between continuation of in-home care and institutionalization. Experience with the implementation of even a small scale respite benefit can provide critical information about issues such as administration, appropriate eligibility criteria and quality assurance. This information will be essential to the future development of a more comprehensive benefit.

Ultimately, Congress should include in-home respite care in the Medicare home health benefit. Eligibility should be based on a broader definition of functional and cognitive impairments.

Elimination of Periodic Interim Payments for Home Health Agencies

This proposal eliminates the availability of a longstanding method of payment for home health agencies known as Periodic Interim Payments (PIP), effective with the initiation of a proposed prospective payment system (PPS) on October 1, 1999.

PIP is a system which projects an agency's expected Medicare home health payments and provides biweekly reimbursement to the agency based upon that projection. Under PIP, adjustments for underpayments and overpayments are made throughout the fiscal year in order to achieve reimbursement consistent with total amount owed by the end of the fiscal year.

Periodic Interim Payments have been essential for many home health agencies in order to maintain an appropriate cash flow to meet the labor-intensive cost of delivering home health services. Unlike many other health care providers, such as hospitals and nursing facilities, home health agencies do not have ready access to capital or credit due to a lack of profits through cost reimbursement and limited capital equity. PIP has helped providers avoid interest costs and revenue shortfalls which could jeopardize the continued delivery of services to patients.

The industry has expressed a willingness to accept the elimination of PIP corresponding with the implementation of the industry's PPS plan. The Administration's proposal however, while eliminating PIP at the implementation of PPS, does

not provide the type of interim PPS system proposed by the industry which would allow for home health agencies to build capital pending the transition to PPS. NAHC recommends that PIP, in this case, be eliminated twelve months after the implementation of episodic PPS.

Payment Under Part B

This section amends Section 1833(a)(2) of the Social Security Act, conforming payments for Medicare Part B home health services to the amended cost limit provision and interim payment methodology set out in the President's package. In addition, it has the effect of eliminating the lower of cost or charges principle from the determination of rates of payment. Currently, Medicare limits reimbursement to home health agencies based on the lower of its costs or charges. This proposal will continue an exemption from the lower cost or charges principle for certain public providers that offer services at a nominal charge.

While the provision appropriately modifies Part B payment structures to conform with the overall payment reform measures affecting home health services under Medicare, it may have inadvertently eliminated application of the lower of cost or charges principle. The NAHC supports the elimination of the lower cost or charges rule (LCC). However here, the proposed action eliminates LCC only for Part B and not for Part A.

V. OTHER ISSUES OF IMPORTANCE TO HOME CARE

Waiver of Liability

Also included in the BBA and closely linked to enactment of PPS was a provision to extend the presumptive status of the waiver of liability for home care, a provision of great importance to NAHC.

In 1972 the Health Care Financing Administration created a presumptive waiver of liability status for Medicare providers. Under the presumptive waiver, providers were presumed to have acted in good faith and were paid for services to a Medicare patient if their low error rate demonstrated a reasonable knowledge of coverage standards in their submission of bills. The presumptive waiver was later incorporated into legislation which after several extensions expired for home care and hospice on December 31, 1995.

The BBA would have extended the presumptive waiver for home care until October 1, 1996, when the Act provided that a prospective payment system would be established for home care. When the Act was vetoed, the presumptive status of the waiver expired.

To make matters worse, HCFA has imposed a system which presumes fraud by assuming providers knew their claims would not be covered, forcing providers to appeal each claim. Reconsideration of claims costs the federal government approximately $400 per claim, and costs providers in the range of $150 for each claim, just to reach the point of requesting waiver protection. If the dispute moves to the Administrative Law Judge level, the federal government and the provider each incur likely costs of $1,000 per claim reviewed.

In order for a home care agency to be compensated under the waiver presumption, its overall denial of claims rate had to be less than 2.5% of the Medicare services provided. Any agency that exceeded this limit was not reimbursed under the presumptive waiver. This requirement forced agencies to use due diligence in determining eligibility and coverage.

Given the vague application of constantly changing regulations, guidelines, and directives, it is difficult enough for home health agencies to be 97.5% correct in their determinations of eligibility. The high number of claims denials that are reversed (25% at reconsideration stage and 70% at the Administrative Law Judge level) shows that coverage decisions are not as clear cut as HCFA asserts. At a time when sicker patients are admitted to home care following earlier hospital discharges, coverage questions are more complex, and the buffer zone of the waiver presumption is particularly important.

Congress enacted the presumptive waiver to encourage home health agencies to provide services to Medicare patients, and to save on the considerable administrative time and expense of handling appeals in cases where agencies are delivering services in the good faith belief that the services are covered by Medicare. In the absence of the waiver presumption, agencies will have no recourse but to reject clients if there are any doubts about coverage. The waiver presumption for home health agencies and hospices should be permanently reinstated and made retroactive to January 1, 1996.

Copays

We are gratified that the President's FY98 budget proposal does not include the imposition of copayments on Medicare home health services. Imposition of a home health copayment would create a new "sick" tax on the most frail and vulnerable elderly and disabled Americans—those who could least likely afford it. Moreover, the policy is "penny wise and pound foolish" and may end up costing the Medicare program more since patients who cannot afford the copayment may defer necessary services, resulting in subsequent nursing home placements, hospitalization or care from other more costly institutions.

Medicare home health copayments do not take into account the in-kind contributions made by Medicare home care patients toward the cost of their care. When Medicare pays for the care of an individual in a nursing home or hospital, it also pays its share of the cost of the building, maintenance, overhead, food, heat, and other significant costs, none of which Medicare incurs with home care. In addition, home care patients, families, and friends make significant contributions to care through "sweat equity." Individuals who receive no Medicare reimbursement provide significant care to Medicare home care patients, as home care nurses train family members and friends to provide care at home.

When the home health benefit was first enacted in 1965, it contained a copayment requirement. This copayment was later dropped because it cost Medicare more to collect in administrative costs than it saved the program. Copayments were a bad idea then, they are a bad idea now.

CONCLUSION

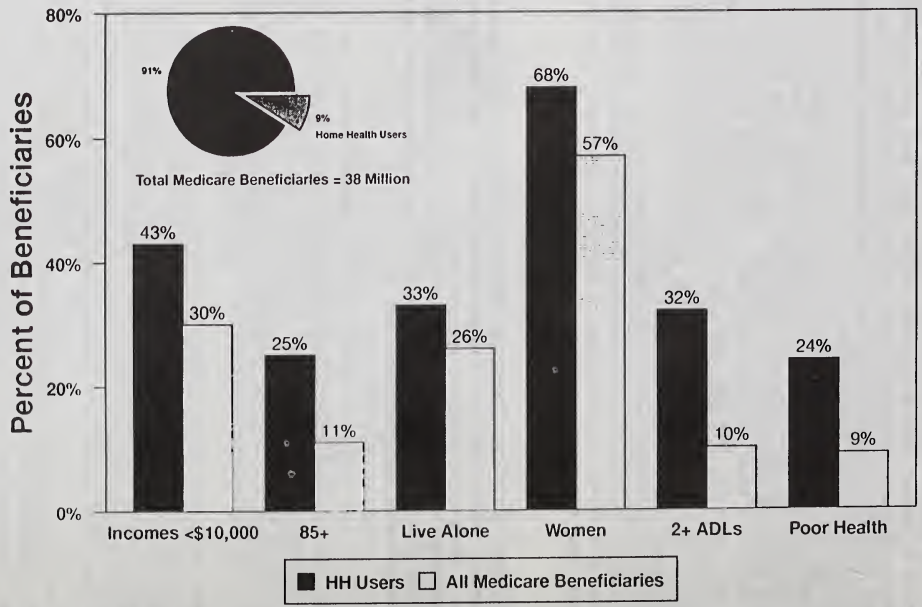
Thank you again, Mr. Chairman, for the opportunity to present our views. Home care has waited for many years to get to this point in the development and consideration of a prospective payment system for home care. You and the Committee have our thanks for bringing the issue to this level of consideration and we look forward to working closely with you in bringing PPS to enactment and on the other important issues facing home care this year.

RULE 4(B)(2) STATEMENT

I hereby certify that the National Association for Hone Care, a witness before the House Commerce Committee on Health and Environment, receives no Federal grants or contracts of any kind.

MARY A. STONER, *Vice-President for Finance,*
National Association for Home Care.

Characteristics of Medicare Home Health Users



Source: HCFA, 1994 Medicare Current Beneficiary Survey

HOMECARE

NATIONAL ASSOCIATION FOR HOME CARE
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Washington, DC 20003
202/547-7424, 202/547-3540 fax

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GENERAL COUNSEL

February 28, 1997

The Honorable William M. Thomas
U.S. House of Representatives
2208 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Thomas:

The undersigned state home care associations urge you to oppose any attempt to shift funding for home health care from Part A to Part B of Medicare.

Home care provides a wide range of vital health care services for 3.5 million elderly and disabled Americans. The Medicare home health benefit allows these individuals to remain in their own homes, often avoiding more costly hospitalizations.

Shifting partial funding for the benefit from Part A to Part B of Medicare would not achieve true savings toward reducing the federal deficit, nor would it address the underlying issues surrounding the impending insolvency of the Hospital Insurance (Part A) Trust Fund.

The A to B shift may also make home care more susceptible to Part B copays, which are extremely regressive, as well as attempts to "bundle" home care payments with hospital DRGs or with other post-acute provider payments. The proposal could also result in tremendous increases in Medicare administrative costs.

We urge your support of maintaining home health care as a Medicare Part A benefit, as well as your support for enactment of a prospective payment system for Medicare home care.

Sincerely,

The Undersigned Members of
The National Association for Home Care Forum of State Associations

HOMECARE

Forum of State Associations A to B Letter

February 27, 1997
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Alabama Association of Home Health Agencies
Alaska Home Care Association
Arizona Association for Home Care
Home Care Association of Arkansas
Home Care and Hospice Assn of California
California Assn for Health Services at Home
Home Care Association of Colorado
Connecticut Association for Home Care
Delaware Assn for Home & Community Care
Capital Homecare Association
Associated Home Health Industries of Florida
Georgia Association of Home Health Agencies
Georgia Assn of Community Care Providers
Georgia Staffing and Home Care Association
Hawaii Association for Home Care
Idaho Association of Home Health Agencies
Illinois Home Care Council
Indiana Association for Home Care
Iowa Association for Home Care
Kansas Home Care Association
Kentucky Home Health Association
HomeCare Association of Louisiana
Home Care Alliance of Maine
Maryland Association for Home Care
Home & Health Care Assn of Massachusetts
MA Council for Home Care Aide Services
Michigan Home Health Association
Minnesota HomeCare Association
Mississippi Association for Home Care
Missouri Alliance for Home Care
Montana Association of Home Health Agencies
NE Assn of Home & Community Health Agencies
Home Health Care Association of Nevada
Home Care Association of New Hampshire
Home Health Assembly of New Jersey, Inc.
Home Care Council of New Jersey
Home Health Services & Staffing Assn of NJ
New Mexico Association for Home Care
Home Care Association of New York State
New York State Assn of Health Care Providers
North Carolina Association for Home Care
North Dakota Assn of Home Health Services
Ohio Council for Home Care
Oklahoma Association for Home Care
Oregon Association for Home Care
Pennsylvania Assn of Home Health Agencies
PR Home Health Agencies and Hospice Assn
Rhode Island Partnership for Home Care
Rhode Island Visiting Nurses Network
South Carolina Home Care Association
South Dakota Home Health Association
Tennessee Association for Home Care
Texas Association for Home Care
Utah Association of Home Health Agencies
Vermont Assembly of Home Health Agencies
Virginia Association for Home Care
Home Care Association of Washington
West Virginia Council of Home Health Agencies
Wisconsin Homecare Organization
Home Health Care Alliance of Wyoming

Revised Unified Proposal for a
Prospective Payment System for Medicare Home Health Services

March 28, 1996

Attached is the Industry's Unified Plan for Prospective Payment System (PPS) for Medicare Home Health Services. It was developed jointly by the National Association for Home Care (NAHC) and the PPS Work Group.

This plan is a modification of the original unified plan submitted to Congress in 1995 as an alternative to Congressional movement to impose copays on Medicare home care services or to bundle home care payments into payments to hospitals. The modifications were made to the original proposal to respond to concerns about implementation feasibility raised by HCFA.

This plan incorporates the best elements of the home care PPS provisions in HR 2491 passed by Congress and HR 2530. It represents months of work and refinement by the home care industry. The plan calls for a three–phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case mix adjuster.

PPS is a more efficient, cost–effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety, or increasing out–of–pocket costs.

We invite your careful review of this proposal. If you have any questions or would like additional information please feel free to contact any of our organizations at the numbers listed below.

National Association for Home Care
Dayle Berke/Lucia DiVenere 202–547–7424

PPS Work Group
Jim Pyles 202–466–6550

3-28-96

Home Care's Plan to Implement Prospective Payment for Medicare Home Health Services

I. Home Care's Goal

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. PPS is a more efficient, cost-effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety.

PPS will be phased in over time, culminating in an episodic prospective payment system plan that should:

- o be developed cooperatively by HHS, the industry, and Congress
- o be acceptable to the industry
- o include extended care
- o be submitted to Congress one year in advance of implementation, and within 4 years of enactment of legislation
- o be approved by Congress
- o include adjustments for new requirements (such as OSHA) or changes in technology or care practices
- o be based on a case mix adjustor that reflects the differences in cost for different types of patients

II. An Interim PPS Plan

An interim PPS plan incorporating certain elements of the Congressional and Democratic proposals (HR 2491 and HR 2530) should be implemented commencing within 6 months of enactment and continue until it can be converted to a pure episodic prospective payment system (Phase III). The interim PPS plan should be based on the industry's design and set forth in legislative language. The interim plan is implemented in phases to provide HCFA sufficient time to collect necessary data and to develop required processes and procedures. Current coverage criteria for Medicare home health services should be maintained and no coverage shifted to Part B.

III. Time Line for PPS Phase-In

Enact Legis.	Begin Data Collec	Begin Phase I Interim PPS	Begin Phase II Interim PPS	Report to Congress on Episodic PPS	Expected Implementation Phase III Episodic PPS
0	2mo	6mo	24mo –30mo	48mo	60mo

IV. PPS SPECIFICATIONS

A. Data Collection

HCFA is mandated to begin immediately to develop a data base upon which a fair and accurate case mix adjustor can be developed and implemented. The data base must be able to link case mix data with cost (and utilization) data.

The data base must include a sample sufficiently large to support the development of statistically valid estimates of payment rates and limits for the geographic area used (e.g., MSA/nonMSA, national, census region).

The data base must contain at least:

- items for the 18 category Phase II case mix adjustor
- HCFA form 485
- UB–92
- additional data items that may contribute to a more accurate case mix system, developed with industry participation (such as items from OASIS)

Payment rates and limits shall be adjusted to reflect cost of data collection

Effective date: 60 days after enactment

B. Phase-In of PPS Beginning with the Interim Plan

Phase I

Prospectively set standard per visit payment (as in HR 2491) with an annual aggregate per patient limit that applies to all visits (as in HR 2530)

Effective date: 6 months after enactment

All currently allowable costs related to nonroutine medical supplies will be included in the data base for calculating the per visit rate, per visit limit, and aggregate limits.

Per visit payment

- standard per visit rate for each discipline calculated (as in HR 2491) as follows:

  the national average amount paid per visit under Medicare to home health agencies for each discipline during the most recent 12 month cost reporting period ending on or before 12-31-94 and updated by the home health market basket index, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located

- amounts in excess of the per visit rate, up to a limit as defined below, may be paid if:
  1) an HHA can demonstrate costs above the payment rate, and
  2) quarterly reports demonstrate that total payments will not exceed the agency aggregate limit

- the payment rates and limits are calculated initially from the base year costs and cost limits and updated by the home health market basket index to the date of implementation; they are updated annually by the market basket index

- base year for payment rates and cost limits – 1994 (using settled cost reports)

Agency annual aggregate per patient payment limit

- base year for aggregate payment limit – 1995 utilization data for each agency

- the blended annual per patient limit is based on the reasonable cost per unduplicated patient in the base year (1994 cost per visit-updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 75% on agency data & 25% on census region data for 12 months following implementation of Phase I, then 50% agency data & 50% census region data

- the blended annual aggregate per patient limit is equal to the number of unduplicated patients served in the year multiplied by the per patient blended limit

- census region: the 9 census region geographic areas (New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, Pacific)

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate per patient cap and below 125% of the census region cost/utilization experience shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limit. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

- Phase I in place 18 months (no longer than 24 months)

Phase II

Prospectively set standard per visit payment with an annual aggregate episode limit for days 1–120 (as in HR 2491); and an annual aggregate per patient limit for visits after 120 days

- o continue per visit payment as in Phase I
- o an episode is 120 days; post 120 day care is paid per visit with an annual aggregate per patient blended limit for the post 120 day period that is separate from the 1–120 day annual aggregate episode limit
- o the HHA is credited for a new episode limit if there is a period of 45 days without Medicare covered home health care services following the 120 day episode (if a patient is readmitted before a new episode can be started, the agency is paid per visit subject to the aggregate episode limit if within the first 120 days, or the separate post 120 day aggregate per patient blended limit if after 120 days)
- o the 18 category Phase II case mix adjustor is applied to the first 120 days, or a more accurate one if available
- o the per episode limit (as in HR 2491) is equal to the mean number of visits for each discipline during the 120 day episode of a case mix category in an area during the base year multiplied by the per visit payment rate for each discipline
- o the annual aggregate episode limit (as in HR 2491) is equal to the number of episodes of each case mix category during the fiscal year multiplied by the per episode limit determined for such case mix category for such fiscal year
- o the region for the episode limit – MSA/nonMSA area
- o the annual post 120 day per patient blended limit is based on the reasonable cost per unduplicated patient receiving care beyond 120 days in the base year (1994 cost per visit–updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 50% on agency data & 50% on census region data
- o the annual aggregate post 120 day per patient blended limit is equal to the number of unduplicated patients receiving care beyond 120 days in the year multiplied by the per patient blended limit
- o the current certification and coverage guidelines continue

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate episode and post 120 day per patient caps; and the post 120 day per patient payments below 125% of the census region cost/utilization experience, shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limits. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

Phase III (as noted under the goal in section I)

Per Episode PPS

- o developed cooperatively by HHS, the industry, and Congress
- o acceptable to the industry
- o includes extended care
- o must be submitted to Congress one year in advance of implementation and within 4 years of enactment of legislation
- o approved by Congress
- o adjustments for new requirements (such as OSHA) or changes in technology or care practices
- o case mix adjustor that reflects the differences in cost for different types of patients

C. Additional Specifications that Apply to All Phases

1. **Exceptions:** The Secretary shall provide for an exemption from, or an exception and adjustment to, the methods for determining payment limits where extraordinary circumstances beyond the home health agency's control including outliers and the case mix of such home health agency, create unintended distortions in care requirements not accounted for in the case mix adjustor payment system. The Secretary shall develop a method for monitoring expenditures for such exceptions. Methods should be developed to allow for additional home care expenditures when they are found to decrease total Medicare expenditures.

2. **Quality:** Any prospective payment system must ensure that home health agencies do not seek to become more cost effective by sacrificing quality. The Secretary will ensure that the quality of services remains high by implementing a revised survey and certification process which emphasizes patient satisfaction and successful outcomes.

   Home health agencies will be required to provide covered services to beneficiaries to the extent that those services are determined by the beneficiary's physician to be medically necessary.

   There will be established a means for beneficiary due process to challenge care and coverage determinations first through internal provider grievance procedures, then through external PRO review.

   There will be established a mechanism for quality review for instances of significant variation in utilization by providers. (this can address both visits and admissions)

Mr. BURR [presiding]. I thank you, Ms. Cushman. Mr. Pyles, 5 minutes.

STATEMENT OF JAMES C. PYLES

Mr. PYLES. Thank you Mr. Chairman. I'm James C. Pyles. I'm appearing on behalf of the PPO work group, which is a coalition of 25 state and national associations dedicated to the prompt implementation of prospective payment for home care. I note that we've spent 3 hours now listening to the problems of home care, and I hope that Ms. Cushman and I can provide you with some solutions. And, I hope that perhaps 1 day we can get comparable time for solutions. I'd like to address a couple of questions that we've heard in our meetings with many of you and your staff, and provide answers that we think make sense.

First, does the home health provider community have a better alternative to the administration's proposal for reducing the rate of expenditure growth for home health services? Absolutely. Over the past 2 years, the home health community has fully developed a prospective payment plan which reduces the rate of growth and home health care expenditures while preserving access to medically necessary services. As you can see from the chart on my right, your left, that plan has been endorsed by the State home health associations of all 50 states, the District of Columbia, and three of the largest national home health associations. It is near unanimous support in the home health community.

An earlier version of that plan passed both Houses of Congress and a conference committee as part of the Balanced Budget Act of 1995, and a revised and improved version of the earlier plan was introduced in the last congressional session by Congresswoman Nancy Johnson as H.R. 4229, as Ms. Cushman mentioned.

H.R. 4229 would replace cost reimbursement with a prospective payment system within 6 months of the date of enactment—no more waiting. The prospective payment plan includes three primary components. First, prospectively establish per-visit rates; second, those rates are subject to annual aggregate payment limits, and third, they're saving sharing, so providers would have an incentive to stay under those limits by having an opportunity to generate savings for the government and for themselves.

Why does the home health community favor prospective payment? We believe that the future of home health depends upon the adoption of prospective payment, because if we're not able to offer an efficient cost-effective alternative to other types of services, home health is in danger of not having a place in the health delivery system. We also believe it is important to reduce the opportunities and incentives for fraud and abuse. We think prospective payment does that.

Why is H.R. 4229 preferable to the administration's proposal? I don't have enough time to list all the ways, but we think it is certainly preferable for the following reasons:

It immediately replaces the antiquated cost reimbursement system and its incentives for higher cost and higher utilization. It achieves true savings for the Medicare program without shifting costs to other programs or payment sources. It streamlines the administration of the home health benefit and reduces administrative

costs both for the government and for providers. It does not resort to arbitrary limits or barriers to access for medically necessary services, and it reduces the opportunities for fraud and abuse.

Hasn't the administration also proposed the prospective payment plan? Absolutely not. The administration's proposal has three principal components:

First, it retains the antiquated cost reimbursement system with all of its perverse incentives until midnight September 30, 1999, and at that midnight hour, it switches abruptly to an unspecified prospective payment plan which cuts cost reimbursement by 15 percent. That will destroy the home health industry. It will throw it into chaos. It also imposes a 3-day hospitalization requirement and a hundred-visit limit on Part A coverage and shifts the bulk of home health coverage to Part B, and you heard from PROPAC that's probably going to be about 85 percent or more.

Will the home health communities plan to achieve scorable savings? Unquestionably, yes. The plan that passed Congress before achieved savings, according to CBO, of $14 billion over 7 years, despite a 67 percent behavioral adjustment. The version of the plan contained in H.R. 4229 was scored by former CBO officials of Price Waterhouse as achieving savings in the $10 billion range. It is important for you to understand that that plan is structured in a way that it will achieve whatever savings are deemed appropriate for home care, and I stress appropriate.

Why is the home health community opposed to the administration's Part B shift? We are opposed to it because it adds costs and complexities to the home health benefit, does not generate any savings for the Medicare program. The prior hospitalization requirement for Part A coverage creates an incentive for unnecessary hospitalizations. It will make fraud and abuse more difficult to detect, as OIG has indicated. It will divert energy and attention away from implementing a prospective payment plan. It will make any prospective payment plan more difficult to implement and administer. It will create irresistible pressure to increase the Part B premium and impose a 10 percent copayment on Part B services. It creates—it requires workers to pay the same FICA taxes for $82 billion less in Part A health coverage, and it will deprive home health coverage to approximately 2.1 million Medicare beneficiaries who are not enrolled in Part B.

The administration states, as justification for its plan, that it simply "restores the original split of home health care payments between Parts A and B," and I quote. And I would refer you to the chart on my left, your right, which shows that for every year in the Medicare program since it began in 1965, the majority of payments has been under Part A, not under Part B. Their statement and justification is factually incorrect.

In closing, just let me say that home care is a popular and humane method of furnishing health care. It has value in the health delivery system as a lower-cost alternative to higher-cost options. In fact, it probably represents the best opportunity for controlling, or for providing, necessary health care services to the post-War baby-boom members as the roll into retirement age.

I would just ask you, let's enact prospective payment now. This industry is ready for it. As you can see, we are unified in support of it. We have waited 10 years for it. Let's just do it.

[The prepared statement of James C. Pyles follows:]

PREPARED STATEMENT OF JAMES C. PYLES, ON BEHALF OF THE HOME HEALTH SERVICES AND STAFFING ASSOCIATION

Mr. Chairman, I am James C. Pyles. I am counsel for the Home Health Services and Staffing Association, which is a member of the Home Health PPS Work Group. I am appearing on behalf of the Work Group, which is a coalition of more than 25 state and national home health associations dedicated to the prompt implementation of a prospective payment system for home health services covered by Medicare.

The PPS Work Group has presented testimony to Congress on this issue on three prior occasions and has worked with Committee staff over the past two years to develop a prospective payment plan for home health services. Therefore, I would like to devote my time today to answering commonly asked questions concerning prospective payment.

1. Does the home health provider community have a better alternative to the Administration's proposal for reducing the rate of expenditure growth for home health services?

Absolutely. Over the past two years, the home health community has fully developed a prospective payment plan which reduces the rate of growth in home health expenditures while preserving access to medically necessary services. As you can see from the enclosed Resolution, that plan, known as the industry's "Revised Unified Plan," has been formally endorsed by the home health associations for all 50 states and the District of Columbia, as well as by three of the largest national home health associations—the Home Health Services and Staffing Association, the National Association for Home Care, and the Visiting Nurse Associations of America.

An earlier version of that plan passed both Houses of Congress and a Conference Committee as part of the "Balanced Budget Act of 1995" (H.R. 2491).

A revised and improved version of the earlier plan was introduced in the last congressional session by Congresswoman Nancy Johnson as H.R. 4229.

H.R. 4229 would replace cost reimbursement with a prospective payment system within 6 months of the date of enactment. That prospective payment system includes

—prospectively established per visit rates;
—subject to annual, aggregate payment limits;
—with savings sharing.

2. Why does the home health community favor prospective payment?

The future of home health depends on the ability of providers to be able to offer an efficient, cost-effective alternative to more expensive types of health care. The current cost reimbursement system penalizes providers who are cost-effective and rewards inefficiency. The current system also creates opportunities and incentives for fraud and abuse.

3. Why is H.R. 4229 preferable to the Administration's proposal?

H.R. 4229 is preferable for many reasons but generally because a) it immediately replaces the antiquated cost reimbursement system and its incentives for higher costs and higher utilization; b) it achieves true savings for the Medicare program without shifting costs to other programs or payment sources; c) it streamlines the administration of the home health benefit and reduces administrative costs for both the government and providers; d) it does not resort to arbitrary limits or barriers to access for medically necessary services; and e) it reduces the opportunities and incentives for fraud and abuse.

4. Hasn't the Administration also proposed a prospective payment plan?

No, they have not. The Administration's proposal has three principal components: a) it retains the antiquated cost reimbursement system, with all of its perverse incentives, until September 30, 1999; b) it calls for an unspecified prospective payment system which abruptly cuts cost reimbursement by 15% effective October 1, 1999; and c) it shifts the bulk of home health coverage from Part A to Part B of Medicare.

Thus, the Administration's proposal does not directly address the underlying cause of the high rate of expenditure growth, fails to achieve true savings without shifting costs to other programs, increases administrative costs and complexity, im-

poses arbitrary limits on coverage, and enhances the opportunities for fraud and abuse. In short, the Administration's plan accepts the status quo and then makes it worse.

HCFA has failed to develop a prospective payment plan for home health despite being directed to do so by Congress in 1987 and again in 1990. Accordingly, it is unlikely that HCFA will be able to design, develop, and implement a prospective payment plan by October 1999. But even if that were to occur, such a plan would not be the product of years of industry thought and input. Nor would the plan be tested. By contrast, the plan contained in H.R. 4229 has been developed through years of research and input by home health providers of all auspices, and the core concepts of the plan have been the subject of two years of testing in the Phase II Prospective Payment Demonstration Project authorized by Congress and approved by HCFA.

5. Will the home health community's plan achieve scorable savings?

Unquestionably, yes. When the earlier version of the plan passed Congress in 1995, it was scored by the Congressional Budget Office as achieving at least $14 billion in savings over 7 years, despite the fact that CBO applied an unprecedented 67% "behavioral adjustment."

The version of the plan contained in H.R. 4229 has been scored by former CBO officials at Price Waterhouse as achieving savings in the $10 billion range over 5 years.

It is important to understand, however, that whatever savings are determined to be appropriate for home health can be achieved under the plan's basic structure.

6. Why is the home health community opposed to the Administration's Part B shift?

The PPS Work Group is opposed to the Part B shift because: a) it adds cost and complexity to the home health benefit, due to the fact that Parts A and B have different billing, administrative and appeals processes; b) it does not any generate any savings for the Medicare program; c) the prior hospitalization requirement for Part A coverage creates an incentive for unnecessary hospitalizations; d) it will make fraud and abuse more difficult to detect; e) it will divert energy and attention away from implementing PPS; f) it will make any PPS plan more difficult to implement and administer; g) it will create irresistible pressure to increase the Part B premium and/or impose a 20% copayment on Medicare beneficiaries; h) it requires workers to pay the same FICA taxes for $82 billion less in Part A health insurance coverage; and i) it will deprive home health coverage to the 2.1 million Medicare beneficiaries who are not enrolled in Part B.

7. The Administration states that its proposal simply "restores the original split of home health care payments between Parts A and B of Medicare."

That assertion is factually incorrect. The Administration's proposal will transfer 60% to 90% of home health coverage and payments to Part B. As shown by the attached chart, most home health services have been covered and paid under Part A since the beginning of the Medicare program. Thus, the Administration's proposal *reverses rather than restores* the traditional split in payments between Parts A and B.

8. Isn't the Administration correct that imposing a prior hospitalization requirement and visit limits addresses the high growth rate in home health expenditures?

No. Skilled nursing facility services are subject to a prior hospitalization requirement, limits on covered days, and even copayments. Yet, the growth rate in expenditures for those services is nearly twice that of home health services.

9. Isn't the Administration correct that the underlying problem with home health is that Part A was intended to cover "post-acute" care services and that home health services are increasingly chronic care or long term care services?

No. Medicare coverage for both hospital and home health services is limited to acute care services. Both types of services must be "reasonable and necessary for the diagnosis or treatment of illness or injury" and may not include "custodial care." More acute care services are being provided in the home today than ever before. For example, most of the acute care following total hip and knee replacement surgery and coronary artery bypass surgery now takes place in the home. Moreover, as Medicare beneficiaries live longer and their average age increases, home health provides more acute care services to beneficiaries suffering from chronic illnesses (as do hospitals). While the illnesses addressed may be increasingly chronic, the services provided are acute and would have to be furnished in a higher cost setting if they were not furnished in the home.

10. Even if the Part B shift is not supported by any principled rationale, shouldn't Congress consider the proposal because it transfers $82 billion in expenditures out of the Part A Trust Fund and extends the solvency of the Trust Fund for 10 years?

The essence of this argument is "let's damage home health providers so the we don't have to damage other health care providers." We believe that if Congress adopts sound public policy, it should not be necessary to damage any health care providers. The home health community has shown that it is willing and capable of producing its proportionate share of necessary savings. Home health accounts for only 8.7% of total Medicare expenditures and should not be required to shoulder a higher percentage of the savings.

In any event, the Part B shift reduces the cost-effectiveness of the Medicare program and does not improve the quality or amount of services that can be provided. It also only extends the life of the Part A Trust Fund by about one-and-one-half to two years. Accordingly, the limited, one-time advantage conferred by the Part B shift does not justify the short and long term damage it will cause to the home health benefit.

Home health is a popular and humane method of furnishing health care. It has value in the health delivery system by providing a lower cost alternative to high cost treatment options. In fact, home health offers the best opportunity for providing necessary health care services to members of the post-war baby boom as they become eligible for Medicare coverage. Please help us preserve the home health benefit for current and future Medicare beneficiaries. Enact prospective payment this year.

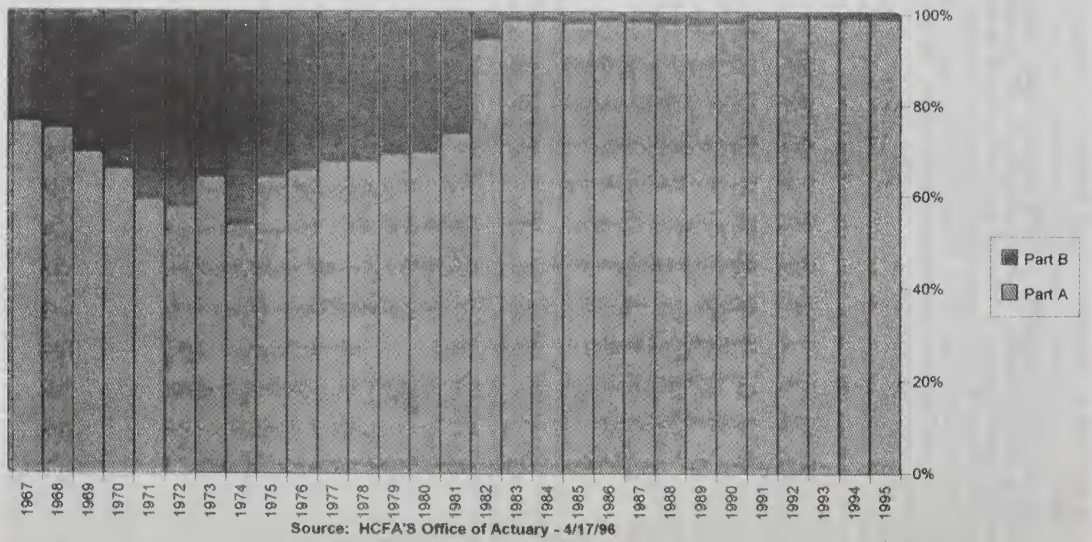
I would be glad to answer any questions.

RULE 4(B)(2) STATEMENT

In accordance with Rule XI, clause 2(g)(4) of the Rules of the House and Rule 4(b)(2) of the Committee rules, I am not in receipt of any federal grant or subgrant thereof nor any federal contract or subcontract during the current fiscal year or either of the preceding two fiscal years.

JAMES C. PYLES,
PPS Work Group.

"The President's proposal restores the original split of home health care payments between Parts A and B of Medicare." Highlights of the President's Medicare Reform Package.



Source: HCFA'S Office of Actuary - 4/17/96

Mr. BURR. Thank you, Mr. Pyles. Given the fact the Mr. Brown and I are the only ones here, we're going to divide the time that's left between now and 1 o'clock, and I want to apologize to Ms. Cushman and Mr. Pyles. I know that we are going to have a vote that's called at 1, and it will be a series of votes. So we're going to do everything we can to end this hearing, hopefully, answering all the questions that Mr. Brown and I might have. That's just a indication that we are going to go back in 15 minutes, I'm hopeful.

Let me start, if I may. Let me go right to where you ended, Mr. Pyles. I raised the question with Dr. Vladeck last week or the week before that I was concerned with the number of seniors covered under Medicare that currently have home health care as a benefit that will lose it based upon the transfer from A to B. Is that a genuine concern on my part?

Mr. PYLES. Well, we don't know what the administration plans to do about the 2.1 million beneficiaries who don't have Part B coverage, but the choices are not very attractive. You either let them lose their coverage or you treat them preferentially by giving them unlimited Part A coverage which other beneficiaries don't have. Or, you give them Part B coverage; you cover them under Part B, under the part that's switched over to part B, and don't require them to pay a premium. So I don't see any attractive——

Mr. BURR. In fact, the way the administration has it written, if a senior who does not have Part B is not hospitalized first, they have no home health care coverage.

Mr. PYLES. That's correct. That's the way I read their proposal.

Mr. BURR. If they are hospitalized, they would have up to one hundred visits under Part A still——

Mr. PYLES. That's correct.

Mr. BURR. [continuing] but there would be no Part B extension granted to those.

Mr. PYLES. That's right. They'd have to have a 3-day hospitalization. You can't even get a mastectomy these days for 3 days—and stay 3 days in the hospital.

Mr. BURR. So, in fact, for a doctor who sees the need for some benefit delivered in the home, for this 2.1 million people, the doctor is encouraged to first put them in the hospital, so that, in fact, they qualify for the home health care.

Mr. PYLES. That's my reading of it. Plus, even for those who have Part B coverage, the hospital is going to have an incentive to put them in the hospital first and get access to the hundred visits because the billing will be simpler.

Mr. BURR. Correct me if I'm wrong. When we moved to prospective pay for hospitals, was there not a transition period that we went through versus a date certain where at midnight on a specified date we switched?

Mr. PYLES. There absolutely was and it was a transition from hospital-specific data to more regional data, and that's exactly the kind of process we have built into the industry's prospective payment plan. We transition from a more agency-specific rate to a more regional or national rate.

Mr. BURR. Why won't the administration adopt your prospective payment plan? What's the problem?

Mr. PYLES. I can't answer for the administration, but I can just tell you we took it to them first in February 1995, worked with them extensively throughout 1995, and they were all in favor of it, at least at the staff level, until the President came out with his budget proposal in September 1995. And, I'm afraid now, I can only conclude that we have become caught up in the political process.

Mr. BURR. But if I understood—and I'm not trying to put words in your mouth, but if I understood your testimony, it made me believe that what we're looking at really isn't prospective pay from the administration. It's not reformed Medicare. It is the elimination, in your mind, of home health care as a service to Medicare beneficiaries in the future. I know that's an observation on your part, but I'm asking if it's a correct assumption.

Mr. PYLES. The clearest way I can analogize, I guess, is to say I guess is to say the emperor has no clothes. There is no prospective payment plan that has been proposed by the administration. It is not there. The only choice we have is not between one prospective payment plan and another one proposed by the administration. The choice is between a prospective payment plan which we have proposed and developed over 2 years, and no prospective payment plan by the administration. Despite the fact they were ordered in 1987 to develop one, they have not developed one to date.

Mr. BURR. Ms. Cushman, is it your understanding that the interim plan is, in fact, the plan that they intend to make permanent?

Ms. CUSHMAN. In listening to Dr. Vladeck this morning, I would not necessarily purport that, and I would point out that when I listened to his testimony, many points of which I thought were quite excellent, that some of the things I found inconsistent with the position they're taking with this interim—with the facts they were stating.

For example, one of the keys is reducing the visit limits, and, yet, one of the things trying to be achieved in the future episodic system is to have the incentive be on total case cost. One can look at all the balloon analogies used today. If you suppress the number or the amount per visit payment, you are automatically increasing the visit—or excuse me—the number of visits in order to offset the same cost to some extent. If we trying to move to an episodic system, it makes much more sense to use the unified system phase one than to arbitrarily reduce limits with no agency ability to shift care, where the industry methodology would use the annual aggregated cost, and if some visit costs were higher and some visits per patient were higher, the provider is responsible for balancing the care. Many Dr. Vladeck's points actually supported that kind of approach.

I would also say that our phase three, yet to be specified, but talking about a pure episodic with a fully developed case mix adjuster, is virtually identical to what I'm hearing conceptually proposed by the administration. And if you read the industry unified proposal and the timeframes for phase-in, if they are truly ready by 1999 with that full episodic, we would applaud them and we could transit directly from phase one to phase three, if they have concerns about the interim, and those timeframes would be perfect matches.

Mr. BURR. Let me ask you one last question and then I'll recognize Mr. Brown. What effect do you believe any type of mandate from HCFA on home health agencies requiring you to only use full-time employees versus contract employees would have on home health care agencies?

Ms. CUSHMAN. I would like to point to the hospice benefit as an area that might provide some example for us. I have trouble as an agency who virtually employs all individuals—we have on employment of over 1,600 individuals, including virtually all of our home health aides. But I say, "virtually," because during peak periods, or during unexpected surges in patients, as you've observed, we are labor-intensive not facility-intensive. We need the ability to contract or add people to do the care that people need.

Mr. BURR. Well, what effect—and I think we have to look at this in its full context—what effect would it have on your business if HCFA said, "I'm sorry, you can't have contract employees anymore."?

Ms. CUSHMAN. If we——

Mr. BURR. Regardless of whether the caseload is an aberration for a month where it goes up, what would that do?

Ms. CUSHMAN. And exactly why hospice allows for peak periods, because that would force us to either choose to not serve patients and create waiting lines when we had insufficient staff or keep idle staff capacity available, and pay all the benefits and all of the other pieces necessary to do that. That would increase costs. So, there needs to be some flex.

Mr. BURR. I thank both of you. The Chair would recognize Mr. Brown for whatever time he may consume.

Mr. PYLES. If I could just comment on one further point she made there about the implementation of the administration's plan, I believe our plan does call for a 2-year phase-in of phase one, and in that period of time, there is no case mix adjuster. Mr. Vladeck expressed concern about that. So we did provide a 24-month or 2-year period for the administration to come up with a better case mix adjuster. And, our plan simply says if he hasn't, or HCFA hasn't developed one by then, we will use the one out of the phase two demonstration project, which is 2 years into experimentation. By then we'll be completely through 3 years of testing.

Mr. BURR. Good.

Mr. BROWN. Thank you Mr. Chairman.

Mr. Pyles, I'm a little unclear on the working group, the Payment Work Group, who you represent. Is it a mix of both for-profit and not-for-profit home care providers?

Mr. PYLES. It's broader than that. It's the State associations of 25 States and also several national; I think it's three national associations. It has both non-profit, for-profit, hospital-based, free-standing—every auspice of home health agency in it you can imagine. But, in any event, the Work Group did a lot of work on the prospective payment plan that we support now. But, the plan now is supported by also the National Association for Home Care, and there is near unanimity in the home health industry in support of it.

Mr. BROWN. And, Ms. Cushman, VNA is not-for-profit; correct?

Ms. CUSHMAN. The agency which I administer is not-for-profit; correct.

Mr. BROWN. Some VNAs around the country are for profit providers.

Ms. CUSHMAN. Essentially, most visiting nurse associations are not; the name was not trademarked in some States. So it's possible that someone could be for-profit and use it.

Mr. BROWN. And the National Association for Home Care, which has had a major presence around here for some time, is a mix of for-profit and not-for-profit?

Ms. CUSHMAN. That's correct. It includes all auspices of home care providers, including official agencies, combined agencies, hospital-based.

Mr. BROWN. Okay. HCFA, through Operation Restore Trust, has taken the initiative to combat fraud and abuse in home health services in some States. Tell us, if you would—this is for both of you, perhaps VNA, perhaps the national association, or perhaps the Work Group—what kinds of steps proactively you've done to combat fraud and abuse.

Ms. CUSHMAN. As the National Association for Home Care, and I detail this in my written testimony, we have a code of conduct which requires any provider who is a member to report any instances of detected fraud or abuse. We have extensive educational programs assisting providers to learn how to set up internal compliance committees and complaints to ensure that even inadvertent misinterpretation will be prevented. The stand in terms of the code of ethics is extensive.

Mr. PYLES. I would just add——

Mr. BROWN. So you were charged exactly like this, and your Work Group would talk about your experience?

Mr. PYLES. Right. The Work Group is really devoted to, and has been devoted to, developing a prospective payment plan. But one of the principal reasons for doing that is to reduce the incentives in the current cost reimbursement system and the opportunities in the cost reimbursement system for fraud and abuse. Many of the instances of fraud that were mentioned earlier in the home health area that have been detected have been cost report fraud, passing things onto the Federal Government that should not be paid for by the Federal Government. Our answer to that is: don't pay costs. Come up with a rate system where you no longer create an incentive for providers to pass costs on.

Yesterday, we had testimony before the Ways and Means Committee, where a representative from OIG said there is no way OIG can ferret out the fraud and abuse and keep up with it on a cost reimbursement system. The only chance you have of detecting it is to change the reimbursement system, and then you'll reduce the opportunities to a level where they can be detected and cured.

Ms. CUSHMAN. Could I amend one thing to my statement? The National Association staff just reminded me that there was legislation introduced—the so-called Sara Webber bill—last year by you, and that the National Association did support that bill.

Mr. BROWN. Three years ago, I believe it was, not last year. Time flies when you're having fun, as you know today by sitting here for 3 hours.

Managed care, for all that criticism that many of us have aimed at the managed care industry from time to time, looks to NCQA and JCHO for accreditation standards and guidelines. Is there any comparable kind of organization that performs that role or should perform that role for you?

Ms. CUSHMAN. There are two accreditation bodies that certify or will accredit home care agencies: JCHO, as well as the National League for Nursing's accreditation program. Both are very fine accreditation programs and require standards beyond the Medicare certification. And, we in the National Association would encourage any other accrediting bodies to also make that available.

Also, we further recommend that consideration be given to minimum standards for home care administrators.

Mr. PYLES. We would encourage that as well. Questions came up earlier of what happens if you go to a prospective payment system, and don't you have heightened concerns for quality? The answer to that is certainly. For that reason, I think you should be aware of there are at least six different measures that would preserve quality.

One, per-visit payments are provided for in our plan, which ensures that some care will get provided.

Second, there is a 10 percent limit on the savings sharing provision, which means you can only—the incentive to achieve savings is only up to a point.

Third, this system creates competition based on the quality, not volume, which currently exists in the cost reimbursement system.

Fourth, there is a current claims appeals process available for beneficiaries that are dissatisfied.

Fifth, there's a Patient's Bill of Rights in the conditions for participation which we just heard have now been beefed-up and broadened and made more specific.

And, finally, there's a peer review system in the plan we have proposed. So there are numerous overlapping provisions to preserve quality.

Mr. BROWN. As of now, though, there is no required accreditation? There's nothing required of home health agencies.

Ms. CUSHMAN. There is not required accreditation. I would also like to add something that Mr. Pyles did not mention, but that Dr. Vladeck did, and that is, which promises great hope, the OASIS data system that is currently being tested by the Health Care Financing Administration and which they intend to make part of conditions of participation. We are one of the 50 demonstration agencies at this point, and we find it an excellent tool for patient care.

Mr. PYLES. And there is no accreditation requirement, but there is a certification requirement. Home health agencies must meet extensive and detailed conditions of participation, and they can achieve what's called "deemed status," deemed to be in compliance with those conditions, if they meet the Joint Commission or NLN accreditation standards. But there is an accreditation process, and only home health agencies that meet those conditions can participate in the program.

Mr. BROWN. Under Medicare?

Mr. PYLES. Under Medicare, right.

Ms. CUSHMAN. It's a basic Medicare certification.

Mr. PYLES. Right.

Mr. BROWN. It is my understanding, under your prospective payment plan, there would be payment per visit. Define, if you would, if we're going to entertain the thought of paying per home health care visit, define a home health visit. What specifically does that mean?

Ms. CUSHMAN. May I actually approach that slightly differently? The pay-per-visit in the proposed plan is what we would call almost a cash-flow mechanism. That is the unit or encounter on which the cash-flows to the agency; the actual settlement with the agency would be based upon the aggregated cap as a final payment. So both enter into the method of payment.

A visit in our organization—and you will find that there is no absolute standard definition of a "visit"—but a visit includes the actual encounter time in the home, the time it takes to travel to and from the home, and the additional time that it takes to prepare for, and deal with, the reporting of a visit, contact physicians, do case coordination after the visit.

Mr. PYLES. I would just add to that by saying agencies currently get paid on a cost-per-visit basis, and we would use the same definition that's currently used, but, as Ms. Cushman says, the actual payment limits under our prospective payment plan are really episodic—first, a year and then, subsequently 120 days, and then a different period.

But the key thing to remember is that an important point in the administration's plan is they limit Part A coverage to 100 visits. Well, if you don't know what a visit is, how can you limit it to 100 visits? So our solution is get out of the business of paying for visits. If you don't know what they are and you can't define them, get out of the business of paying for them. You're never going to win. You're never going to get control of costs, if you keep paying on a visit basis. You're also going to be micromanaging the program.

I would just also point out that the Part B shift is going to create monumental complexities from an operational standpoint. With a 3-day prior hospitalization, is that three continuous days; is that 2 days with a 1-day gap? Does that mean they have to go on home health immediately after being discharged from the hospital? What if they go back in the hospital; is it a different disorder? You've got to bill a different program or a different claims form, different appeals process. It would be a nightmare.

If the intent—and we think the intent should be—is to keep this benefit a low-cost, efficient benefit, the Part B shift goes in exactly the opposite direction.

Ms. CUSHMAN. It would also raise——

Mr. BROWN. Do you oppose the Part B shift as part of the Working Group?

Mr. PYLES. As the Working Group, absolutely, and, yes, the industry opposes it as well, as a unified industry.

Ms. CUSHMAN. We have created what we consider remarkable unification in that virtually all of the proposals that we're talking about, the most core, this prospective payment system, the entire industry virtually agrees upon.

Mr. BROWN. Were you on record, Mr. Pyles, in opposition as an industry, last session when it passed Congress as part of a larger package?

Mr. PYLES. In effect, yes, because when it passed—I think you're talking about when it passed the House—that was before our prospective payment plan had been, we felt, adequately considered. It was considered in part of the Senate bill which went to conference. When it went to conference, the Part B shift was dropped out in favor of prospective payment, which then did pass both Houses. When the bill went back, then the Part B shift did not pass the House as part of the post-conference package, but the industry's—a prospective payment plan did pass.

Mr. BROWN. Okay, thank you very much.

Mr. BURR. I thank you, Mr. Brown.

Mr. Pyles and Ms. Cushman, thank you very much. This is only the start; it's not the end, and I thank you for your testimony.

Mr. PYLES. Thank you.

Mr. BURR. This hearing is adjourned.

[Whereupon, at 1:05 p.m., the subcommittee adjourned subject to the call of the Chair.]

[Additional material submitted for the record follows.]

PREPARED STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.

HOME HEALTH SERVICES UNDER MEDICARE PART A

AOTA represents 59,000 members, a substantial proportion of whom work with Medicare beneficiaries in hospitals, home health agencies, rehabilitation hospitals and agencies, skilled nursing facilities, outpatient clinics and other settings. As the professional association representing occupational therapy practitioners we are committed to the provision of those services by properly trained professionals and to assuring that those professionals are able to practice within an ethical framework which serves the best interests of patients.

The percentage of Medicare payments being spent on so-called post-acute care, including home health services, in the Part A program has been increasing. (*Medicare Spending on Post-Acute Care Services: A Preliminary Analysis,* Congressional Budget Office, January 1997) Many analysts have attempted to understand the reasons for this change, to document the appropriateness and effectiveness of the care provided, and to determine whether this increase is a positive change. In addition, the necessity for cost containment and fiscal responsibility have encouraged examination of the relationship between the growth in non-hospital care and changes in hospital acute care utilization and costs.

AOTA recognizes the need for constraining costs under the Medicare program and stands ready to work with Congress and the Administration to address post-acute care costs for skilled nursing facility (SNF) and home health (HH) services while maintaining high quality services for beneficiaries.

- AOTA supports closer examination of all post-acute care services in order to assure the longevity of the Hospital Insurance Trust Fund and to promote responsible spending under Part B. However, changes to this complex system without adequate examination, analysis and consideration of quality issues could endanger beneficiary health and well-being.
- AOTA supports movement to a prospective payment system for home health services. However, this must be approached with caution and due concern for patient well-being.
- AOTA recommends that design of such a system must take account of a number of critical factors, including eligibility criteria, desired service outcomes, service decisionmaking, personnel qualifications and quality monitoring mechanisms to assure patients receive appropriate services.
- AOTA does not support integration or bundling of payment for home health and other post-acute care benefits at this time. Such an approach has not been well analyzed or demonstrated. Both harm to beneficiaries and inappropriate influences on health care market structure could result.

- AOTA supports improving and enhancing data collection, including the use of standardized coding for all nursing, therapy and other home health services to determine the appropriate mix of services and payment levels as well as to monitor quality.
- AOTA supports review, analysis and modification of coverage criteria for home health.

Home health patients receive services to recover from illness or injury and to prepare to return to more independent functioning. If they recover inadequately or are denied services which can assure recovery or safety at home, they may require further hospitalization or skilled nursing facility care. Providing for the proper type and intensity of therapy services is key to avoiding subsequent costs and we believe this requires continuing development, testing and monitoring.

Occupational Therapy in the Post-Acute Sector

Occupational therapy is an important component of the post-acute care services provided under the Medicare Part A benefit.

Occupational therapy is a health and rehabilitation service, provided by licensed or certified professionals, which uses goal-directed activity in the evaluation and treatment of persons whose ability to function is impaired by illness, injury, disability or normal aging. Treatment goals in the post-acute setting include maintaining, regaining or improving maximum function, adjustment to impaired function, prevention of further injury or complications, and increase in independent activity.

In the post-acute care setting, occupational therapy is provided in the treatment of individuals with a variety of diseases, conditions or functional limitations, including the following: Cerebral vascular accidents (stroke); Alzheimer's Disease; Cardiac conditions; Arthritis; Parkinson's Disease; Cancer; Hip fractures; Amputations; Neuromuscular conditions; Multiple Sclerosis; Cerebral palsy; and Arteriosclerosis

Occupational therapy practitioners evaluate patients' disabling conditions and functional limitations. A treatment plan is developed to ameliorate the condition, improve or regain function, and achieve as full recovery as possible. Occupational therapy is provided to:

Remedy, prevent or reduce disability through interventions which increase joint motion, muscle strength and coordination, and balance, e.g., following a hip replacement.

Through therapeutic adaptations such as assistive equipment and physical environmental modifications, promote mobility and enable the individual to be as independent as possible by overcoming the limiting effects of a physical, mental or visual condition, e.g., following a stroke.

Provide education and retraining through special, individually designed techniques and methodologies to assist the patient to perform essential and instrumental activities of daily living such as feeding, dressing, personal hygiene, and meal planning to increase the independence of an individual and speed recovery of function.

Provide sensorimotor treatment for strengthening, endurance, range of motion, coordination and balance, e.g., following a cardiovascular accident.

Analyze capacity and improve ability in thinking and analysis through therapeutic activities for memory, orientation, cognitive integration, and decision-making, e.g., for an individual with Alzheimer's disease or Parkinson's disease.

Analyze need for and implement programs for safety techniques to avoid injury for individuals such as women vulnerable to broken hips from falls, e.g., an individual with osteoporosis or weakened by treatment for conditions such as cancer or pneumonia.

Provide analysis and implementation of programs to enable cardiac and other patients with limited physical reserve to perform daily activities with limited expenditure of energy.

Occupational therapy's theoretical underpinnings are based on the physical and psychological implications of illness, injury, disability and aging, and on analysis of the components of activities or "occupations." The clinician's knowledge of adapting tasks and modifying the environment to compensate for functional limitations, combined with training in anatomy, physiology and related disciplines, is used to achieve recovery and improved function.

Current Service Design: Skilled Nursing Facilities and Home Health

Skilled nursing facility services are an important component of Medicare Part A Coverage. These services provide the post-hospital patient the skilled services that are necessary to recover from illness or injury and to regain optimal levels of health and function.

Under Medicare Part A, beneficiaries are entitled to 100 days of SNF care following a minimum three-day hospital stay. In order for a SNF stay to be covered under Medicare, the patient must need daily skilled level services provided by a registered nurse, physical therapist, occupational therapist, or speech-language pathologist, as determined by a physician. After the 20th day of a SNF stay the beneficiary is liable for a daily co-payment equal to $95.50.Home health care is provided under Medicare Parts A and B. Occupational therapy is available to patients who *first* qualify for home health by needing skilled nursing services, physical therapy or speech-language pathology services. Patients must also be homebound.

In this context, occupational therapy is provided to assist individuals to improve function and thus be able to live *without* home services more quickly. Occupational therapists analyze the individual patient's needs in their home environment and increase ability to provide for self care.

There are no co-pays and no limits on home health services other than meeting the continuing requirements for eligibility, including medical necessity and appropriateness.

Current Utilization: Home Health Services

There are similar factors which affect the increased utilization of home health services.

- The Omnibus Budget Reconciliation Act of 1980 eliminated the hospital stay requirement under Part A for home health, the Part B deductibles, and the 100 visit limits under both A and B. This deliberate action to make services available to those who need them contributed greatly to the increase.
- Changes in age composition, growth in the Medicare population, advances in technology for home-based care, and changes in acute care payment have also affected increases.
- Need for home health services is not related only to acute health conditions or simply diagnosis. *Even the Prospective Payment Assessment Commission in its testimony before the Ways and Means Committee's Subcommittee on Health on March 5 noted that in home health "patients' service needs often depend on multiple factors. For example, functional status and social support needs may be more important than diagnosis in predicting resource requirements for home health patients."*
- The changing pattern of service use tends toward extended services of home health aides rather than skilled care, reflecting a changing purpose for home care. Rather than acute care, it has moved to respond to an unmet need for patient's with chronic conditions.
- More effective regimens for the rehabilitation of the home health patient produce *better outcomes* in terms of higher levels of function. See "Patient-Level Cost of Home Health Care Under Capitated and Fee-for-Service Payment," *Inquiry*, 32:252-270, Fall 1995.)

While all of these factors contribute to the growth in Medicare costs for the home health patient, there is a measurable return on this investment in reducing future costs and in the improved quality of life for patients treated. Medicare beneficiaries are living longer and also want to maintain functional independence longer. Supports such as appropriate post-acute and home care contribute to these goals.

Prospective Payment: Need for Accuracy, Accountability, and Quality

Prospective payment systems can create desirable incentives for more efficient and economical behavior as well as increased predictability of costs; however, there can also be significant risks to the accessibility and quality of services. Therefore, such efforts must be made based on adequate data and include quality monitoring standards. Such an approach must support improved patient outcomes and assure patient access to necessary and appropriate care. Any system for skilled nursing facilities, home health, or rehabilitation/long term care hospitals must be carefully designed, tested, implemented and monitored to assure the systems serve patient needs as well as fiscal goals.

Prospective payment can create incentives for under-service. Many of the skilled professional services—including the services of occupational therapists—are provided under arrangements with home health agencies. Payment incentives for skilled nursing facilities and home health agencies could result in inappropriate limitations on these critical services unless there is careful monitoring of patient access to needed services.

The challenges of structuring prospective payment systems are substantial obstacles to moving forward despite relatively broad consensus on the desirability of such an approach. The heterogeneity of the patients treated in home health, the lack of

reliable patient classification systems, and disagreement over outcome standards have all contributed to the delay in moving to a prospective system.

In moving to a new payment *home health* system, there are a number of important considerations: insuring patients have access to appropriate services; assuring the quality of those services including assurances that services will be provided by qualified personnel; adequacy of payment levels to meet specific patient needs; and linking payment with appropriate patient outcomes.

These principles must be held to under a *home health* prospective payment system. Particular regard must be given in design and implementation to assuring that patients get the highest level of service they need not just the least expensive. Most of the proposals put forward or tested over the past several years have been similar, establishing per visit cost limits and aggregate agency limits. The general direction of these approaches may be suitable but any new payment system must be built around a valid classification system and a foundation that assures that services are appropriate and that they are provided by qualified individuals. Improved data collection, using standardized coding to define services and employing a more clear definition of visits, will enhance this system.

Home health agencies must be held accountable for providing patients access to medically necessary and appropriate therapies. Better data on current practice will allow development of better standards against which quality will be measured.

However, some proposals include an allowance for agencies to be rewarded for their cost effectiveness. *Offering financial inducements or rewards to providers based on how much they save below a cost limit is a prescription for underservice and denial of patient care. Incentives for savings should not take precedence over incentives to provide appropriate care. The use of bonuses to providers to encourage savings may do so at the expense of patients.* While appropriate incentives could be used to promote cost effective care, a conservative approach, carefully implemented and monitored, must be used.

Coverage of Home Health Care

A particular concern for AOTA is the use of the outdated qualifying service method for determining coverage policy regarding home health. This requirement is not justifiable under a prospective payment system. Determination of coverage should be done based on characteristics of patients and services should be targeted most appropriately and efficiently to meet those needs.

Current law with regard to home health qualifications, however, limits access and choice for consumers, places administrative burdens on providers and intermediaries, and is not cost effective in requiring additional services to be provided. Current law only allows coverage of occupational therapy as a home health services if the patient has a need for skilled nursing services, physical therapy, or speech-language pathology services. This is inappropriate from a clinical standpoint because a patient's need for occupational therapy will not necessarily be conditional on the need for another service. Often times occupational therapy is the most appropriate and only intervention necessary to enhance a patient's functional status and enable him/her to remain independent and safe in the home.

Current law is also flawed from a policy and program integrity perspective because it may encourage unnecessary utilization of skilled nursing, physical therapy or speech-language pathology services in order to qualify the patient to receive occupational therapy.

When a prospective payment system for home health is implemented, this limitation would unreasonably restrict choice on the part of patients and providers to select the most appropriate and effective service. A prospective payment system would include many incentives to speed a patient's recovery and discharge from home health. Prospective payment may also require a different decisionmaking process in determining which services are provided in a limited time and under constrained funding. Current Medicare law makes it difficult, and sometimes impossible, for an elderly beneficiary to get occupational therapy, which may be the only service the individual needs or which could be the key service to achieve optimum recovery for that individual. As a result, the individual's progress may be impeded, the original debilitating condition could worsen, and the possibility of costly acute care or placement in a skilled nursing facility is increased.

Occupational therapy should be an available skilled service to any patient who needs it as part of the home health benefit. Because its goals are to increase independence and functioning, it would also contribute to the effectiveness of the prospective system because it would allow agencies to provide services as soon as possible which can move a patient toward independent function and consequently less need for supportive home health services.

A change in the overall approach to coverage would allow occupational therapy to be defined as a qualifying service or would otherwise restructure the threshold requirement for eligibility for home health services would allow people who need only that service to receive it directly without requiring receipt of another service. Medicare law clearly supports occupational therapy as a free-standing, critical home health service. Occupational therapy can continue to be provided *after* the need for the qualifying service (physical therapy, skilled nursing, or speech-language pathology services) has ended.

In addition, occupational therapy may be underutilized in the current home health system (accounting for only small percentage of the total visits) because of this skewed eligibility criteria; yet, occupational therapy is an essential service directly targeted at improving independent function and decreasing need for services such as home health aides. To better understand appropriate services and to better predict utilization, *AOTA recommends that a demonstration project be done using coverage criteria that allow occupational therapy as a qualifying service or an eligibility system which uses an alternative to the qualifying service approach to determine the effects on costs and outcomes.* Such a project could examine the current eligibility criteria and provide better information on which to build a prospective system.

To endorse a radical change to the system such as prospective payment while ignoring other problematic aspects of the home health benefit perpetuates the piecemeal approach which underlies many of the problems we now face in the Medicare system.

Payment System Design Issues

A *patient classification system* is an essential tool for grouping patients with similar conditions and expected requirements for care. Any such system must: consider a broad spectrum of patient characteristics including the patient's diagnosis, other medical conditions, functional limitations, need for services, and outcome potential; assure that cases or episodes are relatively homogeneous with respect to the professional services required; and provide for a data reporting system that permits appropriate monitoring and measurement of the quality and outcomes associated with its use.

One example of such a classification system tested by the Health Care Financing Administration (HCFA) for skilled nursing facilities is the resource utilization groups (RUGs) which is currently being used in a prospective payment demonstration program involving skilled nursing facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas. Phase III of the demonstration incorporates payments for therapy services into the prospective daily rates. However, at this point, it is not clear whether RUGs will be adequate for use as a payment tool or whether the project will yield sufficient information to design a nationwide prospective payment system for skilled nursing facilities.

Home health patients need to be categorized as well. Other demonstrations have investigated this; several proposals put forward use a system which also has been tested by HCFA.

As prospective systems are designed, patient goals must be defined and incorporated into the monitoring system. Previous proposals from Congress and the current proposal from the Administration contain no desired or expected patient outcomes for either home health or skilled nursing care. These are not mentioned as part of the overall approach to improve the payment system. *Cost effectiveness improvements must be linked to patient outcomes.* Episodes of care or levels of reimbursement must be designed with quality care and achievement of optimal health and functional outcomes as paramount objectives.

Quality monitoring mechanisms or expectations must also be outlined to assure that funds are equitably allotted to patients based on patient need and establishment of desired patient outcomes. Control and monitoring of quality of care and patient outcomes are not inconsistent with prospective payment; indeed if a system is built based on identified patient need, more cost effective services will be provided.

Need for Improved Data Collection

A problem highlighted in the ongoing reporting and analysis of the Prospective Payment Assessment Commission and others is the problem with current data. Under both the home health benefit, data about what constitutes a visit or treatment session, what interventions are performed and how much time is spent are virtually non-existent. This lack of data will limit the appropriateness of any prospective payment system. *Improved and enhanced data collection* must precede the implementation of a prospective payment system and must also be used to monitor implementation.

AOTA supports the proposals put forward by the Administration and others to require coding for procedures provided in skilled nursing facilities and would recommend extending that requirement to home health services. Nursing, therapies, and other services should be recorded using consistent coding (e.g., use of HCPCS for therapies) to better understand current services, to develop a reliable prospective payment system with a solid patient classification system, and to effectively monitor quality of care after a prospective payment systems is put into use. It is important to extend this coding through some mechanism to nursing services. These services are significant in the request for exception payments under the current skilled nursing facility payment system and thus should be better analyzed. Nursing and nurse aide visits also comprise a majority of home health visits.

AOTA also supports the Administration's request for authority to require reporting of additional data from post-acute care providers, including home health providers.

Summary

Changing the payment system for post-acute care should proceed gradually with appropriate transitional periods to avoid unnecessary disruptions for patients and providers. Prospective rates should also include categories for outlier or exceptional cases, for changes in technology, advancements in therapeutic practices, and a reasonable allowance for inflation. Finally, parallel to any implementation plan for prospective payment must be an evaluation component so that appropriate mid-course corrections can be made.

Although we have not been privy to legislative language details, the information we have had thus far forces us to express serious apprehension about the potential impact on patient care of the proposals to quickly implement prospective payment systems for home health and skilled nursing facility services under Medicare. While we reiterate our support for the concept, we also reiterate our concerns about implementation on too rapid a timetable.

In particular, we are strongly opposed to the Administration's request for authority to implement new payment methodologies and to integrate payment systems without further legislative oversight. AOTA believes that this request denies the Congress its appropriate role in designing both the benefits and payment approaches for the Medicare program.

AOTA is ready to assist the Congress to better understand the importance of these benefits and the complexities of payment. We are eager to work on the important issues of assuring appropriate cost containment while assuring quality patient outcomes.

PREPARED STATEMENT OF JAMES L. SCOTT, PRESIDENT, PREMIER INSTITUTE, PREMIER, INC.

Mr. Chairman and Members of the Subcommittee, on behalf of Premier, Inc., which represents major integrated delivery systems across the country and one-third of the community hospital beds in the nation, I am pleased to have the opportunity to share our views about Medicare payment policies relating to postacute care services, especially home health and skilled nursing facility (SNF) care. As this Subcommittee well knows, Medicare expenditures for these services have been rising much more rapidly than outlays for most other facets of the program. Moreover, the proportion of Medicare patients receiving home health and SNF care, and the average amount of such care per patient, are rising.

The Role of the Medicare Part A Trust Fund

As you know, the President has recommended that Medicare's Part A Trust Fund retain responsibility for paying only a portion of the home health services received by Medicare beneficiaries (i.e., up to the first 100 visits following a three-day hospital stay). All other visits, including those that are not immediately preceded by a prior hospitalization would be paid from the Medicare Part B Trust Fund. While this proposal has been skeptically received in some quarters, we believe that it is quite defensible, especially given the significant changes over time in Medicare's home health benefit and the current status of the Part A trust fund.

However, we also believe that the proposal needs to be modified so that the new financial burdens imposed on the Part B Trust Fund are shared fairly between Medicare beneficiaries and taxpayers-at-large. We believe that a portion of the home health costs that would be allocated to the Medicare Part B Trust fund should be borne by Medicare beneficiaries through inclusion in the Part B premium. In fact, the Blue Dog Coalition Budget recently unveiled advocates this kind of approach. Specifically, it recommends that the transferred home health costs "be counted in

the calculation of the Part B premium for all beneficiaries with incomes above $30,000 a year." Premier considers this concept an equitable approach.

Bundling Post-Acute Care Into the Hospital PPS

For nearly fifteen years, Medicare has paid for impatient hospital care on a prospective, per-case basis, using a diagnosis-related classification system. In contrast, Medicare has continued to pay for home health and SNF services using a cost-based methodology. The Administration now proposes a *per diem* prospective payment system for SNF services beginning in fiscal year 1998, and a separate prospective payment system for "an appropriate unit of service" for home health in 1999. No doubt, these proposals are an offshoot of still-unfinished demonstration projects undertaken by the Health Care Financing Administration (HCFA) in the hope of devising separate, prospective payment policies for home health and SNF care. At this point, however, there are many unanswered questions regarding the Administration's proposals. Nevertheless, in our view, the bundling of home health and SNF services into the *existing* PPS would be far preferable to investing considerable resources in *separate,* fee-for-service payment methodologies for these services, especially methodologies that result in payment on a per-diem or per-visit basis, rather than on a much more global basis (e.g., per case).

Under a postacute care bundling approach, a hospital could receive a single payment for both the costs of an impatient stay and necessary postacute services, and would be responsible for ensuring that the patient received all necessary care. Since a prior three-day hospital stay is a prerequisite for Medicare coverage of SNF services, all Medicare-covered SNF services could be bundled into PPS under this approach. Further, since a large proportion of the Medicare beneficiaries receiving home health services have had a preceding hospital admission, these services could also be bundled into PPS. For example, in 1992, about two-thirds of Medicare home health users began their episodes of care within 30 days of being discharged from a hospital. Looking at it another way, a postacute care bundling approach would provide a ready-made way to distinguish between those home health services that are covered under Part A of Medicare and those that are covered under Part B and would be perfectly compatible with the proposal to allocate home health spending between these two trust funds.

In designing an appropriate postacute care bundling methodology, four key tasks would need to be accomplished: (1) defining the bundle of services to be covered; (2) identifying an appropriate patient classification system for payment purposes; (3) developing a method for determining the appropriate payment amounts and addressing a variety of related issues (e.g., the need for exceptions or outlier payments); and (4) settling the question of which entity or entities should receive payment for the bundled post-acute services. With respect to patient classification, the system of diagnosis-related groups (DRGs) already in use appears to provide a ready-made solution. In fact, a recent study published in the Fall 1996 issue of *Inquiry* (A. James Lee, Randall P. Ellis, and Angela R. Merrill, "Bundling Post-Acute Care (PAC) with Medicare DRG Payments: An Exploration of the Distributional and Risk Consequences", *Inquiry* 33: 283-291) concluded that "hospital-level risk actually would be reduced if post-acute care were bundled with the DRG payments for impatient stays." Of course, over time, it may be necessary to further refine the DRG classification system to account for differences in the postacute care needs—and costs—of patients now classified in the same DRG. However, such refinements would be no different that the many other changes in the classification schema that have already been made for a variety of reasons.

Of course, the bundling of postacute care undoubtedly would raise questions about the impact on quality of care, treatment outcomes, and utilization of services. Moreover, consideration should be given to the need for changes in existing Medicare statutory and regulatory requirements, and appropriate beneficiary coinsurance and copayment obligations for the bundled postacute care services would need to be devised.

If payment for postacute care were bundled into the hospital impatient PPS, the result would be a single responsible entity (the hospital), which would no longer see its obligations to the patient end at the time of discharge. Such bundling would also give hospitals more flexibility in deciding how best to meet a patient's needs, and in what setting. Finally, such a policy would dispel any appearance that hospitals are "gaming" the system when they discharge their patients to affiliated postacute care settings.

In short, while we recognize that bundling postacute care into PPS raises a number of issues, such an approach appears to present clear advantages over continued reliance on per-diem, per-visit or other relatively fragmented payment methodologies, where multiple providers share responsibility and where it is conceivably easi-

er for an individual patient to "fall between the cracks," or for one provider to shift a care burden to other providers, perhaps in response to the incentives provided by Medicare payment policy. While a postacute care bundling policy is initially likely to cover only SNF and home health care, it could eventually be expanded to cover care now received in other postacute care settings. Congress should mandate demonstrations in postacute care bundling policy and assure that at least the same level of resources is devoted to this integrated delivery system approach as has been directed toward other postacute care payment alternatives. This policy would benefit Medicare beneficiaries and would reduce the fraud and abuse in a portion of the delivery system that is so fragmented.

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